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An Address.[1]

By A. E. COATES,
Lieutenant-Colonel, Australian Army Medical Corps, Abroad.
(Retiring President of the Victorian Branch of the British Medical Association.)

AT the time of my election to the office of President of this Branch of the British Medical Association there seemed little prospect of an appointment in the Australian Imperial Force. However, at ten days' notice I sailed for service overseas. My resignation was not accepted by the Branch Council and I was requested to continue in office. Such a gesture could not but be sincerely appreciated. The burden has fallen on my successor, Dr. Boyd Graham, and he has faithfully carried out the manifold duties, during a very worrying year, with a zeal and dignity deserving of our warmest praise.

A perusal of the minutes of the Council meetings indicates that a great volume of work has been done, nor have the efforts of the Council been in vain. The close collaboration between the Coordination Committees and our Association has been most encouraging. The medical manpower position is improved and gives one cause for confidence. The tangled skein of workers' compensation difficulties seems to have been unravelled, and solutions have been found for problems which a year ago seemed insoluble. Much time and thought have been given to the reorganization of the medical profession.

Out of the welter of discussion nothing very revolutionary has yet emerged; but it is evident that many of our members are ready to adapt themselves to the changed conditions which will obtain during the years of war and the post-war era. Our profession is playing its part and its importance has been recognized by the Government.

As the nation girds its loins for the titanic struggle in which it must inevitably be engaged, so the medical profession will close its ranks and wholeheartedly devote itself to the common cause. Just as our soldiers adapt themselves to the new methods of warfare and to the diverse conditions of service in various theatres of war, so our doctors on the home front will cheerfully take their places in the reorganized medical divisions of the civilian army. Our job is to assist in winning the war against the Empire's enemies and at the same time to continue the special task which is our life's work—the fight against disease.

In view of the changing economic and social picture in Australia as a result of the war, it would be unwise for me to offer any suggestions at the present juncture. I have observed the civil medical service in Malaya, and with many other medical officers stationed there I have listened to discussions at special meetings, dealing with the advantages and disadvantages of the full-time government-controlled service which exists in that country. Our medical officers are becoming informed—a necessary preliminary to an intelligent appreciation of the problem.

I note that the Council has during the past year closely scrutinized various schemes for modification of the present system of practice. We know that in a democracy the public will be served and that our function in public life as among our patients is advisory more often than executive. It is consoling to realize that under whatever system we as doctors are called upon to function, nothing need impair the zeal and enterprise with which we pursue our labours. The scientific meetings of our Association have for long been among its most useful activities. One of the strange phenomena which an observant layman might note is the tendency among medical men, when they forgather, to hold a clinical meeting.

[1] Read by Dr. H. C. Colville at the annual meeting of the Victorian Branch of the British Medical Association on December 3, 1941.

It has been my privilege for a number of years to be the convener of the Science Subcommittee of the Branch Council, and it is perhaps fitting that my remarks should be directed more to the technical and scientific than to the political activities of the Association. I propose, therefore, to regard this meeting as one of the ordinary monthly meetings of the Branch and to discuss briefly surgery in Malaya.

Notes on Surgery in Malaya.

The duties of a military surgeon are numerous and varied. It is understood that the welfare of the troops is his first care. He examines recruits for their enlistment, watches over them during their training, inoculates them against disease, carefully supervises their food and water supply, directs their hygiene in all its many aspects, and when they are sick or wounded he treats them or directs their transfer to the appropriate medical unit. In whatever part of the world the army may be engaged, whether in active fighting or in garrison duties, the system is the same.

There are some special aspects of surgery in the tropics which may be of interest to medical men in Victoria. By the allocation of Australian units to the Far East, especially the equatorial zone, such as Malaya, there are presented to the doctors who accompany the troops, and also to some extent to the medical officers who attend to "repatriates" in Australia, certain problems that are not within the ambit of medical and surgical work in temperate zones.

The geographical proximity of Australia to the equatorial areas, and in part the tropical conditions obtaining in northern Australia, together with the awakening of our country to the need for strong forces in these regions to guard the front door of our island continent, impose upon the medical profession, through its educational agencies, the urgent necessity of adequately equipping its members with a training in tropical medicine and surgery.

The surgeon in the tropics must pay attention to more than mere technique. He must be more than a craftsman or mechanic. This is true in any part of the world; but it is even more so in those regions where it is not uncommon to find multiple diseases in the same patient. A background of pathology and medicine is essential for the army surgeon in the torrid zones. So it is good for the surgeon to be catholic in his outlook, versatile and apt to learn, for the army in the tropics has no place for the one-track mind. Technical ability must be combined with a knowledge of disease in its varying manifestations.

The climate in this region is characterized by a high average temperature, but, what is more important, a high humidity. This condition, together with the absence of any marked change of seasons, day and night being of almost equal length all the year round, proves somewhat monotonous to men who have been accustomed to the bracing changes of weather in temperate zones. A lethargy is thus easily induced unless certain disciplines of living are practised. If definite rules are observed, life can be not only tolerable but comfortable.

It is essential to have regular work. The healthy appearance of our troops, who devote six hours in the first half of the day to trench digging, gives the lie to the statement that the white man is incapable of heavy manual work in this climate. Wearing only boots and shorts, these men are able to carry on their job, their tanned skin no longer irritated by the combination of sweat and clothes. The afternoon siesta is desirable for men working under such conditions, but is not necessary for those performing lighter duties. In fact, the siesta is better regarded as a luxury to be indulged in occasionally by the brain worker. The latter must take regular daily exercise; but sudden bursts of violent exertion should be avoided. Mosquito-proof nets are provided for all troops, and thus protection is afforded during sleep. Frequent baths, two or more a day, are desirable, but not always obtainable. Proper drying of the skin, especially of the flexures, and the use of dusting powder for the groins and feet are the surest means of avoiding the commoner skin affections, such as intertrigo. "Prickly heat" is easily controlled by bathing, by the use of *Lotio Hydrargyri Perchloridi* (1 in 500) and by discarding clothing whenever possible. Alcohol should be avoided until after sundown. Whisky (half strength) with copious diluent is the popular drink. Diet is similar to that to which we are accustomed at home. Fortunately plenty of tropical fruit is available. Men of easy adaptability, such as those of the British and Chinese races, are thus able to live quite comfortably in these regions.

Certain diseases are more frequently encountered here than in our country. Among them are malaria, dengue fever, amœbiasis, bacillary dysentery, scrub typhus and hookworm infestation. These diseases affect the white population, and although they are essentially medical in that they are diagnosed by the physician and pathologist and treated by specific medical measures, it is incumbent upon the surgeon to make himself familiar with the salient features of these diseases and to be able to recognize them when they are present alone or in association with other conditions for which surgical aid may be necessary.

Other diseases seen in the natives in Malaya are yaws, leprosy, sprue, beriberi and occasionally typhoid fever. Venereal disease is common—syphilis, soft sore, gonorrhœa, *granuloma inguinale* and lymphogranuloma (or climatic bubo).

Most of us who have been in Malaya for several months have become acquainted with these diseases. We are fortunate in being closely associated with the civil hospitals. The civilian doctors—British and native—have helped us by showing patients at weekly clinical meetings and by consulting with us in problem cases of this kind among the troops. The high standard of work, especially in public health and tropical medicine, developed under the ægis of the civil medical administration, explains the fact that this country is no longer a "white man's grave".

Of the malaria control I shall say little. The health of the population of the towns and villages is a tribute to the intelligent application of science to the problem of control of the numerous diseases which once took heavy toll in this country. It is said that every sleeper on the north-south railway line represents a dead Chinese. Malaya's gift to the world, to use the words of Sir Leonard Rogers, has been malaria control.

The genius of the British for colonial administration is nowhere better exemplified than in this peninsula. A number of colonies and federated and unfederated States are here provided with organized engineering, educational, medical and legal services, which are an object lesson to the discerning visitor. In passing, let me say that the officers of these services have extended every possible help to us during our sojourn in the country.

Surgery as practised in Malaya differs only in a few respects from that in Australia. Operations may be undertaken with impunity. There is an absence of dust and flies. Clean wounds are not readily contaminated and healing by first intention is the rule. On the other hand, lacerated wounds sustained in the jungle become contaminated and are slow to heal. In cases of indolent ulcer, not uncommonly seen after abrasions of the lower extremity, it has been found that cleansing of the sore and treatment with red palm oil (our substitute for cod-liver oil) are most effective in producing rapid healing.

The selection of antiseptics for skin cleansing requires some care. The liability to skin irritation is greater because of the constant perspiration and the danger that fungous infection may spread over irritated areas. For skin preparation we use tincture of iodine reduced to half strength by dilution with spirit; it seems to be the safest and cheapest material available and has caused no trouble. For skin sutures, fishing gut and linen thread are used.

The risk of skin trouble presents a problem in the treatment of fractures; adhesive strapping and "Elastoplast" may produce dermatitis, hence skeletal traction is the more suitable method of maintaining extension in fractures of the lower limb when continuous traction is required. The Kirschner wire and Steinmann's pin are both used in appropriate cases. Enclosure of limbs in non-padded plaster casts is similarly not free from danger to the skin. In several cases in which it was necessary to keep a limb encased in plaster for a long period (eight weeks or

more), early removal of the cast was desirable because of skin trouble. Tinea or staphylococcal dermatitis spreads beneath the plaster casts, and the long period of immobilization so essential in such fractures as those of the carpal scaphoid is often quite impracticable. We have tried incorporating mild antiseptics, such as flavine and mercurochrome, in the water in which the plaster bandages are soaked; but no great benefit has been derived from these measures. In fractures of the lower limbs plaster casts must be changed and the skin cleaned before another is applied. When possible, as in the case of larger plaster casts for the lower limb (spicas), we have found it necessary to enclose the part in a layer of cotton wool and mould the plaster carefully over the fracture site and especially about the joints. The inclusion of strips of wire at the flexures, such as the hip and knee, and in the cervical and lumbar regions in cases of injury to the back, has proved of great value, increasing the strength and reducing the bulk of the cast.

In compound fractures of the limb bones and in osteomyelitis a plaster casing has been used where skeletal traction is unnecessary. After cleansing and incision or excision of the skin the whole limb is smeared with zinc cream before enclosure in the plaster cast. Frequent changes of the portion of plaster saturated with discharges seems to control the tendency to skin maceration. Sulphanilamide does not appear to make much difference. It will thus be appreciated that the treatment of fractures requires modification of the technique usually employed in Australia.

It is sometimes stated that operations in the tropics are more dangerous because of sepsis; however, we have not found it so. In 30 cases of ruptured medial meniscus in which operation was performed, no sepsis developed. Incisions in the groins, axillæ and other hairy parts tend to become mildly infected, and when possible they should be avoided. The anæsthetic agent employed for major operations is ether given by the "open" method. Spinal anæsthesia and local infiltration anæsthesia are used in the same manner as in Victoria. "Pentothal Sodium" is useful for short procedures.

Let me utter a word of warning to men who examine recruits for tropical service. A history of skin disorder, the presence of large old scars over the subcutaneous portion of bones (tibia or fibula), old bone disease and serious head injury should disqualify the recruit at once. Adherent scars break down in the tropics. Brain contusion, not sufficient to cause disability in civil life, becomes a real cause of persistent headache or impairment of concentration and mental energy, or both, when the soldier is subjected to the stress of work in these areas. The same strictures apply to foot deformities. Minor degrees of flat-foot, and more especially claw-foot (which in civil life cause little disability) become major problems. Callosities develop, and aggravation by sweating in heavy army boots soon causes the soldier to seek relief. Usually the toning up of the leg muscles and a lighter job put the patient on his feet again; but too many have to be permanently invalided. Operations for the cure of *hallux valgus*, hammer-toe and allied deformities are undertaken only in the absence of gross arch trouble, and then only with the consent of a cooperative patient. Ingrowing toenail is treated by conservative measures. When operation is necessary, simple removal of the nail with or without an ellipse of adjacent skin is advised. Radical operations are best carried out at a home base, if at all. The flare-up of sepsis follows attempts at complete removal of the nail bed.

Operating theatres in some larger civil hospitals are air-conditioned. Without this provision operating is somewhat fatiguing, and constant mopping of the perspiring surgeon is necessary to avoid wound contamination. This problem of ventilation or air cooling in military hospitals is now being considered by the responsible authorities.

The presence of other disease, such as malaria or dengue fever, during the onset or later course of acute abdominal conditions may be confusing. A patient may have a history of abdominal pain and nausea, and tenderness in the right iliac fossa and some rigidity may be present. The temperature may be 104° F., and there may be a history of a slight shivering attack. The surgeon must not be misled. If he finds the local signs of peritoneal irritation and cannot exclude acute appendicitis or some other emergency, he should beware of accepting a diagnosis of abdominal malaria. It is stated by medical writers that the latter disease can mimic acute appendicitis. Experience in Malaya among infected members of the white population has taught doctors to disregard the ubiquitous malaria when a diagnosis of acute abdominal disease is in question.

During the post-operative period after appendicectomy or herniotomy, it is not uncommon for a patient to have a sudden rise of temperature and feel generally ill. There may be suffusion of the conjunctivæ or aches and pains in the limbs. There need be no alarm, as the dengue rash will indicate in a few days that the fears of spreading abdominal infection were groundless.

It will thus be seen that surgeons must become acquainted with the manifestations of certain tropical diseases and that physicians should not forget that common conditions, curable only by surgical measures, may occur in patients infected by insect-borne organisms.

The microscopic findings in a blood film do not relieve the medical officer of the responsibility for making a thorough clinical examination. The pathologist should not be asked to do more than describe what he sees. The diagnosis and treatment of the patient are the function of the clinician and nobody else. A good pathologist is indispensable, however, in any hospital in the tropics. Special methods of investigation are not confined to the use of the microscope and the immunological reactions. The inspection of the stools for worms, pus or blood, and of the urine for the presence of pus or blood, should be made by the medical officer in the ward. Not only should the orifices at the cephalic end be examined as a routine measure; the caudal end of the patient should be regularly inspected and palpated. To insert a finger into the rectum is no more difficult than to inspect the tongue. The sigmoidoscope should be regularly used for patients complaining of irregular bowel function. Care should be exercised in the employment of this instrument. It should be properly lubricated. It should be passed under direct vision, and not stuck blindly into the rectum. A general anæsthetic should not be administered. Over-distension of the bowel with air should be avoided. If these simple rules are observed, the examination can be carried out with the patient lying on his side in bed. The procedure should be painless, and repeated examinations may thus be easily and conveniently made with little distress to a sick patient. The findings at each examination should be accurately recorded in the patient's history sheet.

The amœbic ulcer may be seen before the parasite has been discovered in the stool. In this connexion the examiner must become familiar with the appearance of various types of ulcers in the rectum. Smears and snippings from the ulcer may be necessary in order to determine the exact nature of the lesion. In one of our cases an ulcer simulating a carcinoma was found on section of a piece of tissue to be due to chronic inflammation, and with appropriate treatment it melted away in three weeks. Thus the surgeon may be of assistance to the physician in the diagnosis and sometimes in the treatment of the dysenteries.

Renal Calculi.

One of the commoner diseases among the residents in Malaya is calculus of the urinary tract. It is a frequent occurrence in the civil hospitals to see stones the size of an orange removed from the bladder. Among the troops renal colic is so common that special rules have been drawn up for dealing with these cases. After a first attack it is customary to take an X-ray picture and examine the urine microscopically. If there are no clinical signs of disease, the above-mentioned examinations revealing nothing more than an odd red blood cell in the urine, the patient is discharged and instructed to consume large quantities of water.

We find that it is not wise to submit all these patients to cystoscopy. Repeated attacks of colic, hæmaturia or pyuria, or clinical signs of disease in the genito-urinary tract, are regarded as criteria for complete urological examination. Even with these reservations cystoscopy is the commonest investigation carried out by our surgical specialists.

Recruits who have been afflicted with calculus or other urinary tract disorder are unsuitable for the tropics.

Other Genito-Urinary Disorders.

Non-specific prostatitis is not infrequent among the troops. Quite apart from the class of case which is venereal in origin whatever the organism present, there are cases associated with symptoms of prostatic inflammation. Rectal examination reveals a tender nodule in the prostate. The urine usually contains *Bacillus coli communis* or a staphylococcus. The passage of urethral sounds usually clears up the trouble. In refractory cases shock vaccine therapy or an injection of "Novarsenobillon", or a combination of both measures, usually proves effective. Prostatic massage seems to do little good.

Circumcision is frequently performed. Many men who would not require the operation in civil life find that the conditions of service in a hot climate, the lack of bathing facilities inseparable from prolonged periods in the jungle and the general tendency to skin irritation all contribute to the development of a balanitis for which circumcision provides the only real cure. With the exception of cases of venereal disease, in which the making of a dorsal slit in the prepuce is quite often an emergency procedure, in many instances men request circumcision for hygienic reasons.

Hernia.

It is generally agreed that muscle tone is not so well maintained in the tropics. Many a latent though patent *processus vaginalis peritonei*, which under home conditions would cause no trouble, opens up widely and inguinal hernia develops. Hence the surgical treatment of hernia is a routine matter in military hospitals here. It might be anticipated that thorough examination of recruits would eliminate much of this wastage due to illness; but the fact remains that a waiting list of patients for herniotomy is regularly found in military hospitals in the tropics.

Varicose Veins.

Varicose veins of the legs are also apt to become troublesome in this enervating climate. Ligature and division of the long saphenous vein at the saphenous opening and injection by means of a ureteric catheter of the distal cut end with two or three cubic centimetres of quinine and urethane effect a cure in most cases. Elderly recruits presenting scars of old varicose ulcers or adherent scars due to old compound fractures of the leg bones do not wear well and usually require early repatriation.

Hæmorrhoids.

The same general rules apply to hæmorrhoids. Injection treatment is palliative only; most patients are best operated upon as soon as the disability prevents them from doing their work. Ligature and excision of the three primary piles is the standard operation.

Post-Operative Considerations.

In all operation cases, as well as in medical cases, convalescence is somewhat delayed. A longer period for complete recovery must be allowed than would be customary in southern Australia. This difficulty will be overcome when convalescent stations are established in the highlands, and conditions for the invalid resemble those in cooler climates.

Tuberculosis.

Tuberculosis is fortunately rare among our troops. Thanks to the routine X-ray examination of recruits on enlistment, very few men having tuberculous disease have arrived in Malaya. Up to date, one case of surgical tuberculosis has been discovered. One man was repatriated because of infection (non-proven tuberculosis) in a solitary kidney, the other kidney having been removed some years ago for that disease.

It is to be noted that tuberculous patients, European or Asiatic, do badly in Malaya. Despite the sunshine, native children suffering from bone tuberculosis seem to fade away and die despite orthopædic and dietetic help.

It takes a long time to develop a good tan of the skin. Sunstroke is unknown. We seldom wear hats.

Blood Banks.

Perhaps it would be premature to mention the present position with regard to blood banks in the tropics. It is impossible to keep blood owing to a variety of factors; plasma is obtained from suitable donors and stored. The process is, however, difficult and cumbersome. Serum is supplied from Australia and can be kept easily even without refrigeration.

Transfusion of blood, whole or citrated "on the hoof", is the only practicable method. We are experimenting with the direct method as described by Dr. Julian Smith, senior.

Glucose saline solution and even normal saline solution are not readily stored, owing to the perishing of rubber stoppers. Glass undergoes changes, so that the pH of solutions is altered and silicates are deposited in the bottles. All glassware for blood work is specially prepared, and when not in use bottles are stored full of bichromate of potash. Contamination is difficult to avoid. The whole problem is now being investigated.

Venereal Disease.

Venereal disease is regarded as a medical, not a surgical disorder. Hence it does not come into the surgeon's domain except when complications occur. Soft sore is common. Mixed infection is often present. The surgeon's knife is rarely called for. In certain cases of climatic bubo going on to suppuration relief may be given by simple incision of the abscess; but no attempt is made to do more than evacuate pus already pointing. The sinuses are slow to heal. The late sequelæ—for example, strictures of the urethra—are treated in the usual manner.

Let me utter a word of warning regarding the effects of arsenical treatment of syphilis. Severe jaundice and even abdominal pain simulating biliary colic have been observed. In one case diagnosis was extremely difficult, and only at autopsy was it finally settled.

Urethritis of chemical origin is not uncommon following the energetic use of irrigation as a prophylactic. In this connexion the milder forms of prophylaxis are encouraged by the army authorities with a substantial reduction in the incidence of urethral inflammation. When one considers the prevalence of venereal disease among the Asiatic population, the relatively low figures for the Australian Imperial Force are very satisfactory.

Wound Dressing.

The art of dressing wounds requires cultivation, and it is to be feared that there is a tendency to discard some of the methods, well tried by generations of surgeons, in favour of the newest so-called panacea. Usually the latter is an attempted short cut, and costly experiments are carried out by all too numerous and sometimes incompetent investigators. It were well for us to refresh ourselves from time to time at those fountains of surgical wisdom at which we were nurtured in our student days. Hilton's "Rest and Pain" and Adam's "Inflammation" are worth reading again.

Conclusion.

There are many surgical problems yet to be solved, and work in the tropics provides the enterprising and thoughtful surgeon with abundant scope for the exercise of his talent. Opportunities for the study of disease in the native population are numerous. Many hundreds of people arrive by air in Australia each year from these tropical areas. The possibility that disease may be carried from

Asia to Australia is now much greater than it was in the days before the aeroplane.

It would appear that the future of Australia is becoming more closely linked with that of the Asiatic peoples on the western seaboard of the Pacific. As a member of the British Commonwealth, Australia will have to assume responsibilities, not the least of which will be concerned with the control of epidemic disease. It is well for us as a profession to view our work in its proper perspective in the scheme of things. Our duty is clear. In the present struggle it is a privilege as individual doctors to offer our services to the country, to be employed, at the discretion of our leaders, where and when such service is most effective. As an association we have a responsibility to see to it that we maintain the traditions of our fathers.

In conclusion, I am sure that I voice the sentiments of the Victorian Branch members overseas when I express the utmost confidence in the President and the newly elected Branch Council. We are assured that the affairs of the Branch are in capable hands, and that the dignity, honour and interests of the medical profession will be maintained. I urge the general body of members to give the Council their loyal support.

ATTEMPTED SUICIDE.

By JOHN MCGEORGE, M.B., Ch.M., D.P.M.,

Honorary Physician, Psychiatry Clinic, Royal Prince Alfred Hospital, Sydney.

A GREAT deal has been written about suicide; but the cases dealt with have been mostly those in which the attempt has met with success, and the subject is no longer alive and available to discuss the motive for his act. Any theories as to the cause for self-destruction must be highly speculative. The following series does not suffer this disadvantage, because it represents, in every instance, unsuccessful attempts, although the majority of subjects made a very real effort to terminate an existence which had become intolerable to them for a variety of reasons.

As might be expected, the most bizarre methods were adopted by the insane, although multiplicity of methods did not necessarily indicate insanity. There were 523 cases all told, and these represented the admissions to the Reception House, Darlinghurst, over a period of exactly three years. The procedure adopted almost universally by the police is to arrest a person who has attempted suicide and to charge him before the Lunacy Court with being "deemed to be insane and discovered under circumstances denoting a purpose of committing an offence against the law, to wit, to attempt suicide". The charge alone should be a sufficient deterrent. The accused is then remanded for seven days for medical observation and treatment. This method of dealing with such people serves a double purpose, in avoiding the unpleasant publicity which accompanies proceedings in a police court and in affording an opportunity to sift the psychotic grain from the hysterical chaff. The majority, although charged as above, were not certifiably insane, and were discharged at the end of the period of remand or before. Few were unwilling to discuss the reason for their action; the majority were quite garrulous on the subject, particularly when the shortcomings of a husband or wife were held responsible.

There are several interesting aspects of the subject, quite apart from the motive, and these include the methods adopted, the time or season at which attempts most commonly occur, and the age periods at which the incidence is highest. All these will be dealt with.

Why do people commit suicide? There is a common belief that all who do are necessarily of unsound mind; but observation of a large number has shown that such is not the case. This belief is probably based on the coroner's finding, in which it is always stated that a person committed suicide while of unsound mind. This finding is a relic of the ancient times when a suicide was not buried in consecrated ground and his property was confiscated by the State, unless it were stated that he was incapable because of insanity of appreciating the nature of his act. Suicide may represent an escape from reality, a deliberate evasion of a person's responsibilities, by destruction of oneself. It is therefore a strategy of the neurotic, a foolish attempt to revenge himself on the world, or a form of self-sabotage—all this because the world will not take him at his own extravagant evaluation. Of course, it is quite possible that a person may deliberately and logically consider whether life is worth living, and having weighed it in the balance and found it wanting, quite dispassionately decide to end it all. Such cases must be rare.

Age and Seasonal Distribution of Attempted Suicides.

Suicides, from the psychiatric point of view, fall into two groups, the sane and the insane. Of the latter, the majority suffer from some form of depressive psychosis. Of the former, many are neuropaths at least. We see the dramatization of life, or in this case death, by the hysteric, the spite attempts by the feeble-minded, the alcoholics and the psychopaths, and those cases in which suicide is a strange form of resentment against life. In this last group probably belong the student suicides in Germany during the reconstruction period, although an hysterical element was undoubtedly superadded. The dramatic must play a great part and have a powerful appeal for the ineffectual, maladjusted individual, who for one brief moment at last holds the centre of the stage. It must have been noted how often some unfortunate, troubled being waits at the Gap for an audience to collect before making the final plunge into eternity.

The present series of 523 subjects consisted of 279 men and 244 women. Their ages varied from fifteen to over seventy years. (One might have thought that the last-mentioned would have restrained his impatience a little longer and awaited the natural course of events.) The highest percentage was between the ages of twenty and thirty years, comprising about 25% of all cases. If we take the age group of twenty to fifty years, we find that 70% occur in this period. The incidence of suicidal attempts in relation to age is shown in Table I.

TABLE I.

Age. (Years.)	Sex.		Total.	Percentage of All Cases.
	Male.	Female.		
15 to 20	17	26	43	8·0
20 to 30 ..	65	70	135	25·0
30 to 40 ..	54	51	105	20·0
40 to 50 ..	55	57	112	21·0
50 to 60 ..	58	23	81	16·0
60 to 70 ..	23	12	35	7·0
Over 70	7	5	12	3·0
Totals ..	279	244	523	100

There is little to choose between the numbers of cases which occur in the three decades between twenty and fifty years. As might be expected, the numbers decrease after the age of fifty. Perhaps a greater spirit of resignation is developed, or it may be that there is a stronger desire to hold on to existence as it nears its close. There is little difference between the numbers in the two sexes until the age period of fifty to sixty years is reached, when the men are greatly in excess of the women. It would appear from this that the involutional period is much more productive of mental disturbance in men than in women.

The seasons seem to play their part in determining the frequency of attempts at suicide. The greatest number occur during the summer months and the least in spring, in spite of the popular belief that the shafts of Eros wreak

their worst havoc during the latter period. Table II gives the figures for the purpose of comparison.

TABLE II.

Number of Cases of Suicide according to Seasons.

Summer.		Autumn.		Winter.		Spring.	
December	70	March	51	June	41	September	41
January	45	April	39	July	45	October	37
February	52	May	32	August	34	November	36
Totals	167		122		120		114

It will be noted that the month which leads all others is December, with a total of 70 cases. The fact that this is the festive season may have something to do with the state of affairs, as alcohol may be a more important factor at this time than at others. There is a tendency on the part of admissions to mental hospitals to have a seasonal incidence also, and it is found that the months of November and December have the highest rate and that the summer is the period in which the greatest number of persons are certified insane (see Table III).

TABLE III.

Number of Admissions to Mental Hospitals for the Year Ending June 30, 1941.

Summer.		Autumn.		Winter.		Spring.	
December	119	March	111	June	93	September	100
January	112	April	84	July	110	October	105
February	111	May	102	August	109	November	124
Totals	342		297		312		329

East[1] draws attention to this fact also and notes that, of 2,701 patients admitted to Brixton Prison in ten years, more were admitted in the months of June and July (actually 573) than in other months. This period corresponds to our summer. He found that peaks also occurred in the months of October and December. He attributed the former to the return of the unskilled labourers to the metropolis after the fruit and hop picking season, and the latter to the increased consumption of alcohol in that month. He offered no explanation of the summer rise. It is possible that the depressing effect of the humidity and the climatic conditions is a factor at this time. Exhaustion and listlessness must be at their maximum during the hot months and must have an adverse effect on the older people.

A study of the actual hour of the day or night at which the impulse to finish everything occurs reveals some surprising facts. Two peak periods are found, one in the morning and one at night. These are 10 a.m. and 10 p.m. By far the largest number of women attempted suicide at 10 a.m., and this accounts for the rise at this time, while the highest figures for men at any hour were for attempts at 10 p.m., which explains the peak at this hour. As may be seen from Table IV, 26 women sought release from their troubles at 10 a.m. and 31 men at 10 p.m. If we combine the figures for men and women, we find that the hours chosen, in order of preference, are 10 p.m., 2 p.m., 4 p.m. and 10 a.m.

It is now possible to proceed further with the study of these figures. More attempts are made in the second half of the day, in the proportion of 360 to 163 or more than two to one. Very few people seem to relish the idea of shuffling off this mortal coil in the early hours of the morning. Apparently some measure of comfort is necessary even in the ending of one's life. The contrast between the two periods of the day is best shown by a graph (Figure I). The coinciding of the two peaks at 10 a.m. and 10 p.m. is shown in the graph. It can be seen that there is a steady rise in the numbers from 3 a.m. to 10 a.m.

TABLE IV.

Hour.	Men.	Women.	Total.
A.M.:			
1 ..	6	5	11
2 ..	8	3	11
3 ..	0	2	2
4 ..	4	0	4
5 ..	2	2	4
6 ..	5	5	10
7 ..	8	5	13
8 ..	7	7	14
9 ..	7	12	19
10 ..	12	26	38
11 ..	14	8	22
12 ..	10	5	15
Total ..	83	80	163
P.M.:			
1 ..	10	7	17
2 ..	22	20	42
3 ..	14	18	32
4 ..	18	22	40
5 ..	23	11	34
6 ..	10	12	22
7 ..	16	14	30
8 ..	17	13	30
9 ..	16	10	26
10 ..	31	21	52
11 ..	10	9	19
12 ..	9	7	16
Total ..	196	164	360

and then a fall with a subsequent rise to the highest point of all, 10 p.m. If graphs were plotted for the whole twenty-four hours to show the difference between the sexes in their choice of a time, it would be found that one was

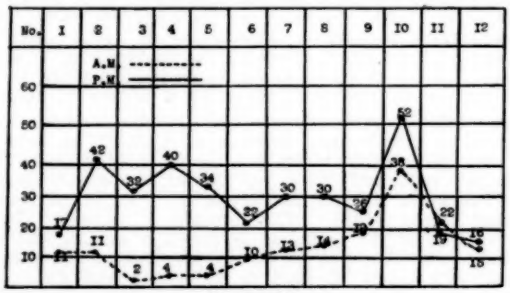

FIGURE I.

Hour of suicidal attempt.

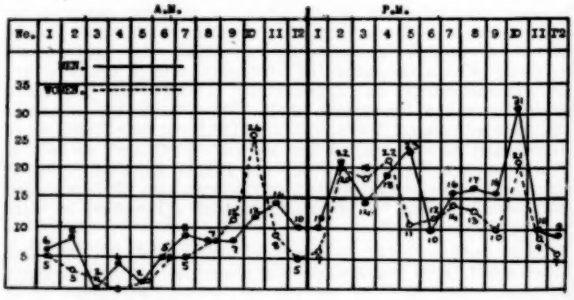

FIGURE II.

Comparison of hours selected by men and by women.

almost the reverse of the other; there would be a peak at 10 a.m. for the women and at 10 p.m. for the men with intervening rises at 2 p.m. and 4 p.m. (see Figure II).

It may be of interest to speculate on the reasons which impel women to select the earlier part of the day and men

the later hours. It appears that the woman finishes her house work and sits down to contemplate morbidly the futility of life and the trials of marriage. To her harassed mind the door of the medicine cupboard opens on the only solution of her troubles. The man returns home exhausted after the day's toil, or perhaps mildly inebriated because of the time spent in convivial company in the local hostelry, to listen to a carefully prepared list of his various shortcomings. Encouraged by the proddings of an acid tongue, he seizes his razor and attempts with one sweep to cut the tie that binds him to this nagging spouse and to the cares of an intolerable existence. These seem to be the most common motives which might account for the time chosen. The reason for the rise in numbers in both sexes at 2 p.m. and 4 p.m. is obscure. East, in his series of cases, also has drawn attention to this, finding the largest number occurring at 4 p.m., with 10 p.m. running it a close second. He accounts for the higher figures in the evening by the fact that it is a more depressing period for the destitute and unemployed, no money being available for a night's lodging, and also because it is a time of physical weariness, hunger, despair and bodily and mental fatigue. It is, of course, during these hours that alcoholic impulsive attempts from quarrels are likely to occur. On the contrary, Morselli[3] found, in 1,993 cases of actual suicide, that most occurred at 7 a.m., 12 noon and 3 p.m. It is difficult to understand why there should be this difference; in most cases it is sheer chance that renders the attempt unsuccessful, as the majority of subjects make a genuine effort to destroy themselves. Morselli's figures apply to Paris, and this may have something to do with the question. It is possible that the mercurial Parisian prefers to select a time that is at complete variance with that chosen by the Anglo-Saxon.

Certain aspects of this subject have been dealt with in considerable detail by various writers, and it is not proposed to discuss them here. This applies more particularly to the question of the religious persuasion of the person and the social condition. It is commonly accepted that Roman Catholics comparatively rarely attempt suicide and that the majority of suicides are of the Protestant persuasion. No doubt the former say with Hamlet:

> Or that the Everlasting had not fix'd
> His canon 'gainst self-slaughter.

However, although they may question this dictum, they infrequently go against it. Sullivan,[6] however, stated that "in Ireland, as in most predominantly Catholic countries, the rate of actual suicide is very low, that of suicidal attempts is relatively high". It is, of course, quite possible that the attempts represented the reactions of disordered minds rather than a deliberate decision to end everything. East[4] also holds this view, and states that "there can be no doubt that strong religious views amongst Western nations frequently act as a check on suicide and suicidal attempts and are amongst the most forceful of preventives in sound minds". In the insane, on the other hand, as is commonly recognized, perverted religious ideas not infrequently cause one or other disaster. All writers are agreed that married and single persons are equally likely to attempt or commit suicide. Strange to say, widowers are less likely to attempt suicide, but more commonly succeed, than either married or single people. Labourers head the list when the subject of occupation is investigated, as might be expected, for the unskilled worker naturally finds life harder than one who has a trade or profession to make employment more certain.

Methods Adopted.

We now come to a consideration of the method adopted. Very little originality is displayed, and, as might be expected, a great deal depends on the accessibility of the means selected. Table V shows the method in order of preference.

It will be seen from Table V that the two most common methods adopted are poison (187 cases, or 36%) and the use of a cutting instrument (112 cases, or 21%). The former is the choice of by far the largest number of

TABLE V.
Method of Suicidal Attempt.

Method.	Men.	Women.	Total.
Poison	71	116	187
Cutting instrument ..	92	20	112
Jump from height ..	32	30	62
Gas	32	22	54
Drowning	12	21	33
Multiple methods ..	9	16	25
Hanging and strangling ..	11	9	20
Firearm	10	1	11
Other methods	10	9	19
Totals	279	244	523

women, 116 in all, and this represents 48% of all women who attempted suicide. The reason for this is presumably its presence in some form or other in practically every home. A comparison of the choice of method between men and women is shown in Figure III. The two methods mentioned earlier afford an interesting contrast, the former being favoured by women, the latter by men.

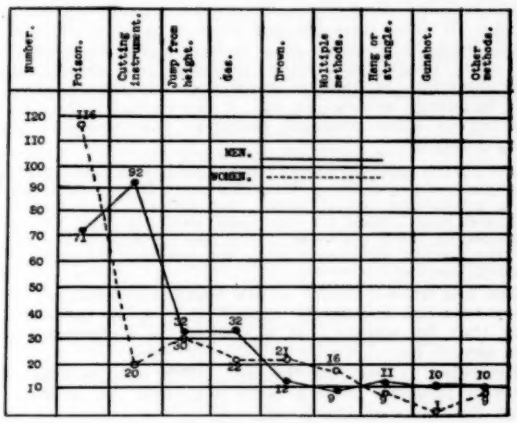

FIGURE III.
Method adopted by men and by women.

The poisons most commonly used are "Lysol" (the first favourite), potassium permanganate and iodine. Others such as arsenic, strychnine, phosphorus, hydrogen peroxide, various liniments, overdoses of barbiturates and even gun oil have been used. One patient, rather optimistically, swallowed 90 aspirin tablets with no subsequent ill effects, except, rather unexpectedly in the circumstances, a severe headache. It will be seen from the graph that there is quite a difference between the numbers of women who try to take their lives by this method and those of the men. East also found that this method headed the list in cases of attempted suicide, although hanging was the most common in successful suicide. Quaffing the poison cup must have its appeal to a person's sense of the dramatic, and must often be used for effect rather than with any real intent to commit suicide. Reference will be made later to this comparison between successful and unsuccessful attempts.

The cutting instrument is usually a razor, and the wounds are commonly inflicted on the throat or wrists. As might be expected, it requires the greater hardihood of the male to make use of this means. If it were not for the fact that the attempt usually happens at night, one might suspect that the sight of himself while shaving arouses such a repulsion that automatically the subject draws the razor across his throat. This theory, unfortunately, is not supported by the facts. Very few women relish disfiguring themselves in this way, and this accounts for the drop in the figures in the case of women.

as shown in the graph (Figure III). In some instances wounds were inflicted on other parts of the body.

Three patients, a woman and two men, cut through the abdominal wall with a knife. The woman proved to be insane; but the male exponents of *hara-kiri* were subsequently discharged from the Reception House.

One man, while under the influence of alcohol, sliced open his scrotum, another battered his head with an axe, while a third cut off his left hand as a form of self-punishment for his sins. (The last complained bitterly, because he did not feel undue pain and thought that he had not suffered enough as a penance.)

One of the most gruesome cases was that of a male patient, who sat quietly in a shed, until discovered by his horrified workmates, chipping away at his skull with a hammer and chisel. He penetrated the bone and lacerated the brain tissue, but made a satisfactory recovery from his injuries, although he remained insane.

The disparity between the figures relating to the two sexes is not so obvious in the other methods adopted, and the graph indicates how closely the figures approximate each other.

Jumping from heights seems to be going out of favour. Since the Sydney Harbour Bridge has been fenced in, the numbers have diminished considerably. The Gap, therefore, remains first favourite. Occasionally a patient decides to precipitate himself from a balcony, often of a public hospital. Heights seem to have a morbid fascination for some people, and often neurotics tell of an almost overwhelming impulse to throw themselves from the top of a building. Strange to say, it is frequently the fear of landing on some innocent passer-by that prevents them from doing so.

One rather unusual case in this group was that of a girl, who jumped from the Sydney Harbour Bridge, but landed on a scaffolding some twenty feet below. She had been attacked and struck on the head and her bag had been snatched on the previous day. She had a subsequent amnesia for the events associated with the suicidal attempt. She made a complete recovery.

Gas has an advantage in its ready accessibility. Contrary to what one might expect, it is more favoured by men than by women. It is difficult to understand why this should be.

Drowning is next on the list. This usually takes the form of jumping from a ferry boat into the harbour or from the rocks on the coast.

One patient revealed a pleasing originality in a series of stereotyped methods. He suffered from a subacute mania, and to express his disapproval of his arrest he adopted the rather unusual course of putting his head into a lavatory pan and pulling the chain with his feet.

Not only does one find that little initiative is shown, but there is a tendency on the part of these people to follow in the footsteps of others, particularly when these lead to the Gap or the Sydney Harbour Bridge. If someone could find a novel means of ending his life, one could be sure that he would soon have his imitators as a result of the attendant publicity.

Multiple methods of attempting suicide, adopted by the one person, do not necessarily indicate insanity. Of the 25 people who tried more than one method of ending their lives, 13 were sane and 12 insane. There were 16 women and nine men in this group. Rarely were more than two attempts made, with the exception of two young girls, whose cases will be described in more detail. The various combinations were: taking poison and swallowing powdered glass in two cases; striking the head violently against the wall and attempting strangulation; taking poison and setting the room on fire; taking poison and jumping from a window; cutting the wrist and jumping from a cliff; drinking poison and throwing self in front of a car; and several others in which poisoning was commonly one of the methods selected. It was usually the failure of the poisoning which prompted the patient to try something else as well.

One case which is of interest was that of a woman who jumped in front of a train, but escaped with a few scratches and then threw herself into a river. She had been unfaithful to her husband and he had her watched by private detectives. He took her back, however, as he lacked sufficient evidence to institute divorce proceedings, one detective having committed suicide himself and the other being sent to jail for false pretences.

The two cases mentioned above were those of a girl, aged seventeen years, and one aged fifteen years.

The former tried to throw herself under a tram and was taken to hospital, where she endeavoured to electrocute herself at an electric light plug. When this failed she swallowed a safety pin and some bobby pins. The whole incident was an hysterical episode largely precipitated by sheer bad temper. The other girl, in a desire to express disapproval of her mother's objection to a girl friend, drank some iodine, which did not have the desired effect, so she promptly jumped into a river. The water was too shallow for her purpose, so she boarded a train and threw herself from it, but escaped with a few abrasions, and then lay down on the railway line, but was rescued by a porter just in time.

This also was a stupid, childish reaction of an inferior mentality.

Hanging or strangling met with little success. Eleven men and nine women tried this but found it wanting. The rope broke or they found the constriction of the air passages so uncomfortable that they had to undo the cord or cloth. In some instances they were found before much harm was done.

The use of a firearm was almost exclusively a masculine method of attempting suicide. Only one woman tried this, and she selected the rather bizarre means of shooting herself in the vagina. It is not clear what she hoped to achieve by this. Perhaps the psychoanalysts may see some obscure phallic significance in the episode. This patient, as might be expected, was quite insane.

Other methods, which are so infrequent that they do not merit a separate classification, include two cases in which the patients sat in motor cars in closed garages with the engines running and waited to be overcome by the carbon monoxide fumes. Some threw themselves in front of moving vehicles, swallowed various objects or banged their heads against walls.

Types of Patients Attempting Suicide.

Of all the patients admitted to the Reception House, 34 had made one or more previous attempts. These included 17 women and 17 men. Twenty were sane and 14 insane. The insane, in every instance, had been certified and sent to an institution after the previous attempt, had recovered and been discharged, but had subsequently relapsed. Half the number selected the same method again. One patient, who attempted suicide only when under the influence of alcohol, showed a consistency worthy of a better purpose. He made six trips to the Gap, which resulted in six admissions to the Reception House. Another alcoholic became "peeved" each time he was locked up in the cells, cut his wrists on two occasions and tried to hang himself on the third. One patient hopefully took 50 aspirin tablets at the first attempt and subsequently tried 25 "A.P.C." powders, with the same lamentable lack of success. All the others tried a different means on the second occasion, but with no better luck. It almost looks as if their hearts were not in it.

Comparatively few patients had relatives who had attempted suicide as far as could be determined. This history was obtained in only five cases, and in only one was it given as the cause of the patient's attempt. This was the case of a mother who took poison after her daughter had committed suicide by drowning because of an illegitimate pregnancy. In the others there were two patients who had brothers who had committed suicide, one whose mother and uncle had both died in this fashion, and one whose husband had taken his own life, leaving the patient to look after five imbecile children. He also had been mentally defective.

Comparison of Methods Employed by Sane and Insane Patients.

A comparison of the methods adopted by the sane and insane supplies some interesting information. This is shown, with the percentages of each in brackets, in Table VI.

TABLE VI.
Comparison of Methods Adopted by Sane and Insane Patients.

Method.	Sane Patients.	Insane Patients.	Total.
Poisoning	164 (42%)	23 (18%)	187
Cutting instrument	64 (17%)	48 (37%)	112
Jumping from a height	45 (11%)	17 (13%)	62
Gas	48 (12%)	6 (5%)	54
Drowning	22 (6%)	11 (9%)	33
Multiple methods	13 (3%)	12 (9%)	25
Hanging and strangling	13 (3%)	7 (6%)	20
Firearm	9 (2%)	2 (1%)	11
Other methods	16 (4%)	3 (2%)	19
Totals	394	129	523

As the sane outnumber the insane to such a great extent, a better estimate of the popularity of any one particular method is obtained by a consideration of the percentages. From Table VI it will be seen that the sane favour poisoning, but the insane prefer a cutting instrument. As has already been indicated, this is used to inflict injuries which are more mutilating than fatal, and represents a desire to pay penance for sins committed as well as an attempt to end life. Actually the position is reversed, poison being the method of election among the sane, with a cutting instrument second, whereas among the insane the opposite applies. Jumping from a height comes third in both lists.

Comparison of Methods used in Successful and Unsuccessful Cases.

East compared the figures in successful suicide cases with those of attempts only, and found that the methods differed in the two. Hanging was the most effective, with drowning next and firearms quite a long way down the list. As the figures were taken from the Registrar-General's return for 1910, gas as a means of committing suicide is not listed. Presumably it was not available at that period for the convenience of those who wished to use it for this purpose. Table VII compares East's figures with those taken from the Reception House records.

It will be noted that with regard to poison and the use of a cutting instrument both series dealing with attempts show a close similarity, although there is some divergence in other respects. The most obvious difference occurs in the numbers of those who jump from a height. Perhaps there are not so many high spots in England from which the patient can throw himself. Apart from this, it will be seen that drowning, hanging and the use of firearms follow in the same order. The successful cases present quite a different picture, and it is only in shooting that there is any similarity in the percentages.

Motives.

The motives which impel a person to try to take his life are worthy of study in some detail. Although the sane outnumbered the insane by more than three to one, the commonest single cause is the mental state of the patient. Table VIII indicates the relative frequency of the various motives.

It is worthy of note that unemployment is last on the list, in spite of the oft-repeated assertion that suicide is at its highest level during times of financial depression.

TABLE VIII.
Motive for Attempted Suicide.

Motive.	Men.	Women.	Total.
Mental state	67	62	129
Alcohol	86	33	119
Domestic worry	35	45	80
Other worries	29	43	72
Ill health	32	28	60
Love affair	12	28	40
Unemployment	18	5	23
Totals	279	244	523

Of the mental disorders, states of depression, as might be expected, are the most frequent. This serves further to emphasize the importance of having depressed patients under strict observation. There can be no doubt that suicide is an ever-present possibility in such cases. A psychosis of some type or other was found to be the cause of the attempt at suicide in 24% of cases—that is, in almost a quarter. A little more care on the part of a relative or a better realization of the patient's frame of mind might well have prevented this. The depression in every instance was a typical one, even among the younger patients, with ideas of unworthiness and feelings of futility and inadequacy. Many authors, including Jamieson and Wall,[45] are agreed that the dangerous time in such conditions is when the patient shows a sudden improvement and appears all but recovered. A sense of guilt, severe hypochondriacal and nihilistic ideas and a history of previous attempts are all of significance in these cases. In the present series 51 men and 55 women suffered from a depressive psychosis. It was most evident in women between the ages of forty and fifty years and in men at a somewhat later period in life. An involutional factor was probably present in both sexes. Other forms of mental disorder played a comparatively small part in influencing the patient to self-destruction. Table IX shows these.

TABLE IX.
Mental Disorders Leading to Attempted Suicide.

Mental Disorder.	Men.	Women.	Total.
Depressive states	51	55	106
Schizophrenia	7	2	9
Paranoid states	2	3	5
Senile dementia	3	1	4
Epilepsy	0	1	1
Mental defect	1	0	1
Manic state	1	0	1
Alcoholic delirium	1	0	1
Anxiety neurosis	1	0	1
Totals	67	62	129

In most of the schizophrenic cases the attempt was the result of a foolish impulse, although one male patient was prompted by the delusion that he was turning into a woman. He appeared to regard this as an intolerable situation. Two patients had ideas of persecution, and it was to escape from their alleged persecutors that they made attempts on their lives. The same motive was at

TABLE VII.
Comparison of Methods in Successful and Unsuccessful Cases.

Suicide.		Attempted Suicide.		Reception House Cases.	
Method.	Percentage.	Method.	Percentage.	Method.	Percentage.
Hanging	27·61	Poisoning	34·0	Poisoning	35·75
Drowning	19·58	Cutting instrument	29·5	Cutting instrument	21·41
Cutting instrument	17·68	Drowning	19·3	Jumping from a height	11·85
Poisoning	16·00	Hanging	8·4	Drowning	6·30
Firearm	7·83	Firearm	2·6	Hanging	3·82
Jumping from a height	1·79	Jumping from a height	0·6	Firearm	2·10

work in the patients suffering from paranoid states. Zilboorg[9] also drew attention to an often unsuspected impulse to commit suicide in schizophrenia, particularly the paranoid type. Not infrequently patients come out of a katatonic stupor to make violent and determined attempts to kill themselves, usually in some bizarre manner. The effort of the mental defective represented a childish endeavour to have his own way. It was a true spite reaction. The epileptic had made several previous attempts as an expression of the typical irritability and contrariness which are found in this condition. There was a depressive element in all the cases of senile dementia, and the woman had some vague persecutory ideas as well. With the exception of six patients, all of those in this group were certified and transferred to a mental hospital.

Jamieson[7] records a series of 100 cases in which a state of depression was found in 75—a high percentage. There were 46 cases of manic-depressive psychosis and 19 of involutional melancholia, and in addition a despondent attitude with pessimism was present in three of five cases of *dementia paralytica*, in one of encephalitis and in four of psychoneurosis. He concluded that the most suicidal patient is the one with the mixed manic-depressive state. He considered that the motives of the insane were to destroy or kill in oneself an asocial primitive tendency or to expiate a sin. In the present series it appears that the attempts represented a penance or an escape from the hopelessness of life or from alleged persecution. In a few instances they were the result of an irrational impulse alone.

Alcohol owes its position in the list to the fact that it is by far the most common factor in the case of men. It is important, not only by itself, but in combination with other causes; but, as might be expected, it plays a relatively small part in the attempts of women. Almost three times as many men as women give this as the explanation of their suicidal attempt. It is possible that alcohol releases some underlying depressive tendency, on the principle of *in vino veritas*, or it may merely be that it induces a state of irresponsibility and lack of control. Although in the case of women alcohol as a factor appears to occur with equal frequency during the whole year, among men it is found most often during the months of December, January and March. At Christmas, New Year and Easter, Bacchus holds sway, and his devotees show a morbid after-reaction to the revels and a readiness to immolate themselves on the shrine. The alcoholics represent more than 22% of all cases. Merrill Moore[10] surveyed the records of 143 alcoholic suicidal patients who constituted 11% of the total suicidal patients admitted to the Boston City Hospital between 1915 and 1939. All were in the habit of drinking excessively, and each attempted suicide either directly under the influence of alcohol or during the period immediately following drinking. The greatest age incidence was between thirty and forty years. There was a constant history of social, economic, occupational or marital maladjustment. Moore concluded that alcohol was probably the most important factor in inhibiting, deranging or rendering less efficient the technique and planning of suicide.

The contrast between alcohol as a factor in attempts by men and in those made by women is shown in Figure IV. It has been placed first for this purpose. The other causes showed comparatively little divergence in the two sexes.

It has been mentioned that alcohol alone is important; but it also appears that other factors may also play their part. These include various worries, financial or domestic, or even in one case discontent with things generally. Table X indicates the relative frequency of these other factors.

It will be seen from this table that it is a common experience to find that the majority of patients who attempt suicide while under the influence of alcohol have no real motive for doing so, and that the whole episode is the result of a foolish impulse, when judgement is obscured and inhibitions are released by the potency of the liquor consumed. The mental states which were associated with alcoholism, as might be expected, were hallucinatory or

TABLE X.

Alcohol in Relation to Attempted Suicide.

Importance of Alcohol.	Men.	Women.	Total.
As sole cause	39	14	53
With love affair	8	1	9
With domestic worry ..	15	7	22
With unemployment ..	9	0	9
With mental state ..	1	3	4
With ill-health	6	6	12
With financial worry ..	6	2	8
With discontent	1	0	1
With stealing	1	0	1
Totals	86	33	119

paranoid conditions. Of the 119 cases, 33 occurred in the age group thirty to forty years. This was the highest figure for any age period and is in keeping with the findings of Merrill Moore already quoted. It included 22 men and 11 women. A number of patients either attempted or threatened suicide on more than one occasion when intoxicated. One patient subsequently died from acute alcoholism, but this was not taken with suicidal intent. Of the 20 sane patients in this series who had made more than one attempt at suicide, ten were alcoholics.

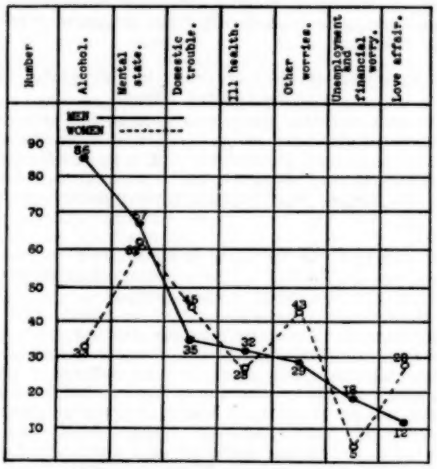

FIGURE IV.

Comparison of motives of men and women.

Domestic worry as a cause is not so frequent as one might anticipate. It was given as a motive in 80 cases (35 men and 45 women), the majority occurring in the age group twenty to forty years—61 in all, or more than 75%. It included unhappiness because of the partner's infidelity, separation or quarrels between husband and wife. Except in the case of separation, the women apparently took the unhappiness harder than the men, as the figures are greater in their case. The actual number of each is as follows:

Quarrel with husband	30 cases
Quarrel with wife	22 cases
Infidelity of husband	7 cases
Infidelity of wife	5 cases
Separation from husband	7 cases
Separation from wife	8 cases
Husband's lack of interest	1 case

As there is little difference in the numbers, one can only conclude that both sexes take the partner's failings to heart with equal seriousness.

Other worries, which do not fall into any particular classification, include quarrels with a relative or friend in 21 cases, financial worry in 16 cases and the loss of a relative in 9 cases. The remaining 26 cases largely consist of single instances of loneliness, suicide of a relative,

mere display, attempts to evade military service or worry about the outcome of the war, which have been advanced to account for the suicidal attempt. The most important of these from one point of view is financial worry. It is so often stated that the economic situation is an important factor that it is of interest to find that only 16 patients—that is, 3% of the total of all patients—found it of sufficient importance to make them adopt this means of solving the problem. Zilboorg, to whom reference has already been made, is emphatic in his statement that recent statistical studies demonstrate that there are more suicides in days of prosperity than in periods of economic depression. These figures seem to support this contention.

Ill health is a more important factor among men than among women, and between the ages of forty and fifty years than at any other period of life. There were 60 patients who attributed their attempts to some physical illness, usually of long standing. One case was that of an organist, who suffered an injury to a finger which prevented her from playing and thus interfered with her livelihood. Pain, particularly if persistent and severe, may be sufficient to drive a distracted patient to seek relief by suicide. This was the outstanding factor in three subjects who suffered intense pain from a fractured jaw, war wounds and renal colic respectively. The last, in a frenzy, sliced open his abdomen with a razor. Other reasons for despair were chronic pulmonary tuberculosis, rheumatoid arthritis, cardiac incompetence, gonorrhœa, loss of an eye, malaria, insomnia, blindness and cataract. The spectre of unemployment among men aged over forty years seems to have magnified in their eyes the importance of even trifling illnesses. It was not the actual loss of a position that caused the mental stress and anxiety, but the fear that it might occur. Unemployment therefore played only an indirect part in these cases.

Love affairs are very much lower on the list than the romantically inclined would have us believe. There were only forty cases altogether, 12 among men and 28 among women. It would seem that the women take their romances much more seriously than men do. Most of these cases occurred in the age period from fifteen to thirty years—28 all told, which is 70% of the total. Of the 28 women who sought eternal release from the shafts of Eros, seven were pregnant and either unmarried or separated from their husbands.

One made a suicide pact with the married man responsible for her condition and sat in a motor car with the engine running in a closed garage. She went to the Reception House and he went to jail.

The remaining cases were all examples of an impulsive reaction to a lover's quarrel. It appears that this is taken much more seriously than are the natural consequences of amorous dalliance. From the age of forty years onwards the numbers decreased rapidly as the sands of sexual enthusiasm ran out, and after fifty there was one solitary male who was prepared to offer his life as a sacrifice to Venus.

Unemployment, as has already been pointed out, does not loom so largely on the suicide's horizon as certain earnest reformers would have us believe. Only 23 patients, or 9%, gave this as the reason for their desire to depart from this vale of tears. It is more important among men than among women in the proportion of 18 to 5, and the greatest number is found between the ages of twenty and thirty years. This factor may have been elevated to a position out of all proportion to its real significance, because it has been held to be responsible in cases of successful suicides, although if all the facts had been available it might have been shown that some other motive had a greater share in producing the result. The only satisfactory manner of determining the truth is by questioning those who have returned from that dark border which separates life from death.

Reference has been made to the ages at which certain motives seem to have their greatest influence. Table XI gives this in more detail.

As all these have been discussed in some detail, it is unnecessary to say much more about them, except to note that from fifteen to twenty years a love affair gone wrong is the most likely cause, from twenty to thirty years domestic worry brings thoughts of suicide, from thirty to forty years alcohol is the determining factor, while from forty years onwards the impelling force is some form of mental disorder.

Having considered the various aspects of attempted suicide, we must ask the question: what can we do to prevent it? As long as lovers quarrel, husbands and wives stray from the family fireside, mental disorders develop and apparently unquenchable thirst exists, so long will vagrant thoughts stray to ideas of suicide. So few make a second attempt that no good purpose would be served by advising institutional care and psychotherapy for those who fail to achieve their purpose at the first attempt. Close supervision of those patients who betray a depressive tendency and the early recognition of the danger signs of self-depreciation and hopelessness of outlook might serve to prevent attempts among the mentally unbalanced; but from the days of decadent Rome to the present time no one has devised a means of telling when an ordinarily sane and reasonable person is going to be overwhelmed by an impulse to self-destruction. This renders the task of prevention well nigh impossible. The improvement of social and economic conditions is not the solution either. We have as much chance of stopping suicide as we have of reforming prisoners and closing our jails, although some masters of hyperbole would have us believe this possible.

Conclusions.

The conclusions to be drawn from the study of this series of cases appear to be as follows:

1. There is a seasonal incidence in suicide, with December the favoured month; and there are also two peak periods of the day—namely, 10 a.m. and 10 p.m.

2. The age period from twenty to fifty years accounts for 70% of cases.

3. Poisoning is the most favoured method, with a cutting instrument second.

4. The most common cause of a suicidal attempt is the mental state, usually of a depressive nature, although the sane outnumber the insane by three to one. Alcohol is an

TABLE XI.
Motives in Relation to Age Period.

Age. (Years.)	Mental State.		Domestic Worry.		Alcohol.		Ill-health.		Love Affair.		Unemployment.		Others.	
	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
15 to 20	3	0	1	2	2	1	0	2	4	10	2	2	5	9
20 to 30	9	8	13	19	20	7	3	7	3	11	7	3	10	15
30 to 40	11	9	13	16	22	11	2	4	2	6	2	0	2	5
40 to 50	14	24	3	5	17	10	10	8	2	1	3	0	6	9
50 to 60	17	14	5	3	18	2	11	2	1	0	2	0	4	2
60 to 70	10	3	0	0	7	2	4	4	0	0	1	0	1	3
Over 70	3	4	0	0	0	0	2	1	0	0	1	0	1	0
Totals	67	62	35	45	86	33	32	28	12	28	18	5	29	43

important factor, both alone and in combination with other causes. Unemployment and financial worry play a relatively small part.

5. No suggestion can be made with regard to prophylaxis. Even in a Utopia the state of absolute perfection would induce boredom and drive someone to commit suicide as a welcome release. It is conceivable that in the Elysian fields some disgruntled individual would gloomily contemplate ending everything because his harp was out of tune or his halo had a dent in it.

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THE DANGERS OF A NATIONAL SALARIED MEDICAL SERVICE.

By ARTHUR E. BROWN,
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IN the medical profession, just as in all other groups in the community, there are optimists and there are pessimists. The optimists take the view that nothing in the way of serious change in our way of living and of work is going to take place. We have only to "stand pat", they say, and everything is going to be lovely. The pessimists, on the other hand, fear that the good days of professional life are gone for ever, that changes are impending which are going to ruin and stultify us and our work, and that there is nothing we can do about it except to advise our sons to choose some other way of livelihood. I have never been enamoured of extremists, either of the optimistic or the pessimistic order. I believe that the really useful members of the community are the realists—men who get quietly on with their daily work, but who have sufficient imagination to sense change when it is coming, and sufficient intelligence to count it part of their daily work to seek out the most appropriate answer to the problems arising and to make the necessary readjustments to meet them; and it is to those realists in the profession that I am addressing these lines. I desire to try to review the present position of medical practice realistically.

The first point to establish is that any change in our organization and status which may be expected to occur is going to come about as a result of pressure from outside our ranks. The medical profession is not seething with discontent. Its members are not working under intolerable or even unpleasant conditions. We ourselves are not in the least likely to initiate any change, except under pressure of outside circumstances. That, I think, can be taken as a fact. Therefore, if the optimists are right, and there is no serious threat to our status from the community in which we work, everything is all right and there is no need to worry. It would suit most of us very well—myself included. The life I have lived in my profession has been, and still is, a very good life; I would never ask for better. That certain amount of overwork and overstrain which cuts off the lives of many of us rather short of the general average, is amply compensated for by the interest and the creative nature of the work we do. So far as our personal predilections go, most of us, myself included again, would be very well content if the optimists should prove to be good prophets. Whether in our inner consciences we could feel in that case that we were doing all that our profession could be expected to do and should do for the service of the public is quite another matter. We would be personally well content for things to go on as they are.

But unfortunately optimists are not always good prophets, and when their optimism proves to be falsified by events they may be dangerous members of the community. There were optimists in Britain in the nineteen-thirties who believed that if we all concentrated on our daily tasks and set the world a good example by unselfish disarmament there would be no threat to world peace. There were optimists in Holland and Belgium to whom it seemed obvious that if they only obeyed to the full the obligations of their neutrality no threat to that neutrality would be likely to develop. And I am afraid I cannot share the optimism of those professional men who see in the present conditions a service to the public so high and satisfactory that no real move to alter those conditions is likely to be made. I think the signs are such as to deny that thesis utterly; and I believe that not many of our members or our leaders are in fact complacent about the future.

Assuming, then, that our present idyllic existence is threatened with change, what are we to do about it? There is no need to recapitulate the signs that apparently indicate such change. If they do not so indicate it, then the optimists are right: everything is lovely, and we need do nothing. For the purpose of this argument we will assume the alternative, that they are wrong.

There are at present under discussion two widely differing forms of reorganization of our service to which the medical profession may have to adjust itself. One is a wide extension of the insurance principle with payment of doctors by capitation fee. The other is a complete abandonment of the fee principle and the substitution of payment by salaries from a central controlling authority. Now, again for the purposes of this argument, there is no need to indicate either of these as in itself good, one "nicer" than the other, or either of them preferable, in its relation to us, to our present way of life. I am quite prepared to assume, not knowing in the least whether it is true or not, that most of us would prefer to continue in our familiar paths and rather dread the uncertainties and the unknown possibilities inherent in either proposal. That is not the point. What is the point at issue is, primarily, which of these two methods is the one most likely to be adopted by the community and, secondarily, under which of them will the medical profession of the future be best able to develop its service in efficiency and dignity.

At this stage I regret that I must interpose a personal judgement from which I cannot escape. It does not affect the argument, but it must be here stated. I am afraid I can see very little hope for future medical organization in a wide extension of the capitation fee principle. Its disadvantages are excellently set forth in the report of the National Health and Medical Research Council of July 24 last. Though that report refers particularly to *The National Health and Pensions Insurance Act* recently passed by Parliament, it is evident that many of the criticisms there expressed would hold in any form of *per capita* payment. For instance, the statement that "under a *per capita* payment *per annum* to each doctor on the basis of his panel list, the only incentive offered to the doctor is that of increasing his income by adding to his panel numbers at the expense of his professional rivals and at the expense of professional efficiency" must hold good for the principle as much as for the particular example. The principle offers no solution to the greatest problem of medical organization—that of efficient distribution of doctors in accordance with need, to which the great obstacle must still remain: the financial interest of the doctors vested in the treatment of sickness. It cannot in my view afford a permanent solution for most of the more important problems of medical reorganization, and therefore could never be more than a temporary palliative measure. When, in addition, it is associated with an "income limit" the stage is set for further trouble. For income limits are rather like those inter-

national boundaries guaranteed for eternity by solemn treaty, whereby is assured the certainty of future revision in discord. I had a small experience of working under the English panel system in its earlier days; and it makes me fear that those who hope to avoid in national insurance the clerical work, the annoyances, the limitations of freedom in prescribing and treatment, which they dread under nationalized medicine, are doomed to disappointment. And further, I am afraid that we shall find friendly societies and insurance companies more insidious masters and less easy to deal with than even a government department might be. However, as I said before this digression, this does not affect the argument I am attempting to set forth. Speaking as a realist to realists, one must admit that there exists in this Commonwealth a very large financial interest vested in the insurance contract principle. The great friendly societies possess large financial and political power; and it is quite possible that neither the medical profession, if it desired to, nor the more enlightened statesmen, may be able to prevent the forcing on the community of the insurance principle as the general basis for the future of medical care. Should it appear that such a development is likely to occur, the duty of our profession and its leaders would be not to fight it blindly, but to see that the conditions of it are such that we do retain the utmost of our dignity and independence; and in particular that we do not fall into a position of dependence on any third party intervening between us and our patients. There is a positive line of defence that should be prepared in advance for such an eventuality, and one that we can with justice and dignity prepare now.

The question of a salaried national medical service is on rather a different plane. In theory it is as correct as the capitation fee insurance principle is faulty. I doubt if there would be half a dozen members of our profession who would not be prepared to admit that a salaried national medical service, if ideally conceived and perfectly managed, would in fact solve all the problems of medical reorganization and provide a perfect medical and health service for the community. The trouble in this case is the fear that such a national service would be in fact far from ideally conceived, far from perfectly managed, and would actually provide conditions so irksome to the average professional man that the better type of men would not undertake the work and the public would suffer gravely. Let me affirm at once that in my opinion such a fear is very largely justified, and that I personally share it. It is a very real danger threatening the medical services of the community, and it is because I believe it to be so that I have been urging my professional colleagues to recognize that danger now, before it eventuates, and to study it in advance.

For let me say again that if the public of this State or of this Commonwealth decide that they want to have a salaried medical service, they will have it; and we shall be morally unjustified in opposing it, and socially powerless to prevent it. On the assumption that the public is going to demand a complete reorganization of their medical services on a salaried basis and under a central authority therefore, we should endeavour to discover wherein the evils that we fear are likely to exist.

The danger does not lie in the fact of the salary itself. Let us lay that bogy aside at once and for all. Efficient salaried services in which professional men enjoy their work are already in existence in considerable numbers. The municipal hospitals of Stockholm are a case in point. Among our own colleagues, too, it has been abundantly demonstrated by university professors, medical officers of health, tuberculosis and mental diseases officers, that to accept financial reward by salary instead of by fee is no obstacle to the performance of work of the highest quality. The danger, to my mind, lies in the methods adopted by and the atmosphere created in government departments. Let me illustrate that statement by quoting to you from a correspondent of mine who was in a full-time government medical service. He wrote to me expressing surprise that I could advocate a national medical service. He said that his life in the service had been so filled by "a thousand daily annoyances, each too petty to protest against" and that he disliked the life so much that he was leaving it to go into private practice. Hearing later that he had settled in private practice, I wrote to him and asked him if he would give me some idea of what aspects of the service he found so irksome, and his reply was both valuable and illuminating. He wrote:

I have stated below *seriatim* aspects of work under a full time paid scheme which I found to be irksome:

1. Records of patients' attendances, diagnosis and treatments were supervised by clerks in a central office. In my opinion work of this nature should be done by medical persons, and such information should not belong to the State, but to the individual.

2. Official control of expenditure was largely overdone, for example, if drugs were needed urgently, it was incumbent on me as medical officer to contact the central office which would issue an order and later forward to me. Such delay in obtaining supplies was often serious.

3. Lack of official enthusiasm in schemes for betterment of hospital facilities.

4. Official censure when emergency called forth unusual procedures, for example, going long distances to cases without official permission.

5. Deductions from salary rate for income tax, car allowance, rent *et cetera*.

These were made apparently at will, and unless one made earnest enquiry the amounts of the deductions were never stated.

These are some of the more urgent reasons why I left the service. The first four hit hard at one's personal liberty and freedom of action (things which most of us prize). The last reason, to me, amounted to absolute insult.

Surely this picture is vivid enough in its description of the dangers that threaten the profession should the formation and constitution of the presumptive national medical service be taken out of the hands of medical men. These are very obvious horrors, and do almost justify my correspondent in the declaration with which he ended his letter: "I regard any move toward nationalization of medicine as a degradation to the doctors who run such a scheme." Almost, but not quite. Had he amended his statement to read: "I regard any move toward such a nationalization of medicine" I would be in entire agreement with him. But in the absence of such amendment we have boxed the compass from the optimist who is sure that nothing evil threatens us, to the pessimist who sees nothing but black ruin ahead of us. And I cannot join the pessimist any more than I can walk alongside the optimist.

I believe that the danger of our finding ourselves in some such position as is depicted by my correspondent is a very real danger. In fact, when I observe the resolute refusal of the majority of medical men to consider such a possibility and to prepare for it I almost become a pessimist. If we do eventually find ourselves tied up in such a service as that, I am afraid we shall have no one to blame for it but ourselves, our conservatism, our lack of foresight, our unwillingness to face facts and to prepare in advance to meet impending change.

I refuse to be a pessimist. I cannot join the optimists. I cannot believe that all is going to be allowed to go on as it has. If they are right and I am wrong I shall be happy personally, though uneasy in conscience. I believe that radical change will be forced upon us, either in the specious form of a national insurance scheme which will allow us perhaps a short breathing space of illusion, in the spurious belief that we retain our independence under it; or in the theoretically correct, but potentially horrible form of complete alteration of our economic basis to salary and central control. But I believe also that we can, if we will, avoid the potential evils of the national service, and can ourselves, if we will, build up a service in which we will be able to live and work in happiness, in dignity and in some pride. What is necessary for that is full recognition of the fact that the actual enemy is not the salary, but the method of control.

Now if one is to hold that all central control is an evil and that our profession in particular cannot work under it in any circumstances, then one must frankly join the pessimists. Medicine holds no future. For some form

of central control lies ahead of us in the years to come as surely as winter follows summer. Therefore the non-pessimist must prove to himself and to others that this is not so. We must admit the dangers inherent in central control. These dangers are constant and will be constant; for it is unfortunately a true saying that "power corrupts". The politically minded among us are likely to be those who drift towards the controlling positions; and the temptation to amass records, to collect inventories, to enlarge staffs, and to exercise interference over the man who is doing the work is and will be strong. Therefore it is necessary that our profession should cultivate a restless jealousy for its independence. It must keep its controlling body always accessible, always professional, and always in close touch with the rank and file. Medical men must in any efficient scheme always remain independent professional beings, capable of assuming responsibility and entrusted with the duty of initiative and independent judgement. They must never be allowed to become names on the card indexes of clerks at Canberra. Every district centre must be to a large extent autonomous. The administrative staff must be as small as possible and must never be allowed to take up a position of superiority over the professional staff. In other words, it must be recognized as axiomatic that the purpose of the service is the maintenance of health and the treatment of the sick, and not the accumulation of dossiers and records, or the saving of treasury funds.

I do not want to suggest for a moment that I am competent to lay out a scheme in which all dangers will be avoided and perfection achieved. What I do want to do is to point out to my colleagues wherein the danger that threatens our future consists, and to suggest that by thought and planning now we may be able to arrive at some method of averting these dangers without putting ourselves at hopeless odds with the public's desires. It is also my belief that we can achieve our own salvation by doing so.

To work out the details is not easy. The subcommittee which was appointed by the Council of the Victorian Branch of the British Medical Association to draft sample proposals for discussion, found particular difficulty in trying to envisage a form of central control which would efficiently but not officiously correlate the medical services with the hospitals, nursing, pharmaceutical and other services auxiliary to medical work proper. There may be found to be many ways and many methods of approaching a solution, but none of them must involve the control of professional work by clerks and accountants, and all of them must aim at the maximum of decentralization. Details are yet a long way from clear, but the sooner they are discussed and clarified, the safer we should all feel. The grievances expounded by my correspondent are real and deadly to any service; and it should be our function as a profession to prevent them from creeping into any national scheme. Patients' record cards must be clinical documents of a highly private nature, and must be the temporary property of whatever doctor is at the time responsible for the patient's welfare. That should be self-evident. Local medical centres should be encouraged in local pride as local hospital authorities are now. And they should be encouraged, too, within the limits of reason, to perfect both their facilities and their amenities. There should be no dead hand of a distant government department intervening between them and their needed supplies. And doctors' salaries should of course be salaries, subject to no deductions but paid as a contracted return for work done. The doctor himself should, as is any other citizen, be responsible for the payment of taxes and other obligations. Promotion on the recommendation of a man's own immediate professional superiors may make mistakes, but it would cause less heartburning and be more human than the shifting of cards in cases in Canberra with right of appeal by all other doctors against the shift.

These are, of course, only illustrative items, to indicate how we must watch this movement and decide what conditions will aid efficiency and happy working; and what will sterilize and stultify the independent professional spirit which must be the life force of any medical service, private or national.

Therefore I appeal again to the leaders of our profession to show foresight and vision. They must realize that it is relatively unimportant whether Dr. A. wants national insurance, Dr. B. wants a salaried service, or Dr. C. wants to stay as he is. If the public are satisfied with our work as it is, they will leave us as we are. If they demand national insurance, we shall be called upon to make national insurance work well. If they decide that they want a salaried national medical service, then into a salaried national medical service we shall go—or else what? The same old obstructive fight with no clearly prepared plan on our part?

Our duty to ourselves and to the public seems to me to be clear. Every State should closely study the position and the possibilities now, before the future crystallizes. I suggest that such study could well be done by special committees appointed for the purpose. You can call them vigilance or medical defence committees if your mind takes that direction, or if you are in a more constructive mood they could be known as medical planning committees. Their duties should be to study the trends of public thought, to try to see from what direction pressure is likely to arise, and what form it is likely to take. They should gather all possible information from men who have actually worked or are working under government salary, and find out what points these men find good and what irksome. They should gain information of various salaried services in the now rather restricted field of overseas countries. They should exchange views and information with similar committees in other States. They should correlate this information as far as they can to form a clear idea of what might be harmful and what beneficial in insurance or nationalized medical schemes. And they should disseminate this information and their conclusions as widely as possible among the Branch councils and subdivisional committees so that the profession itself might be spurred to thought.

That is a fairly large job for men already nearly overborne by the stress of professional work. Yet if we can achieve it I think we have the brains amongst us to formulate a plan to make national service workable consistent with dignity and independence and to be able to avoid the stigma of being again in blind opposition to the desires of the public.

A SIMPLE SAFEGUARD IN THE FEEDING OF PREMATURE INFANTS.

By KATE CAMPBELL,
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IN the feeding of premature infants who are able to take their food by bottle or pipette, the amount taken is limited by the infant's capacity. When premature infants require to be fed by gavage there is no such check, and the attendant can administer feedings of any size. In these circumstances there is a real danger that over-filling of the stomach will cause regurgitation or vomiting of the excess food, which the infants are frequently too weak to expel. The vomitus is then inhaled into the larynx. In this type of infant, if the cough reflex is absent, no efforts are made at expulsion of the vomitus, and it is aspirated into the bronchial tree. As a result the infant may die, literally drowned in his food, or the aspirated material may set up bronchopneumonia, which often proves fatal.

The vomiting of premature babies is frequently ascribed to indigestion, and a feeding of similar size but weaker strength is often substituted, without benefit. I think that in most cases when a suitable type of feeding is given, the vomiting of premature infants is due to too large a feeding and not to the type of food.

On the other hand, it is important that the baby should be given enough food to enable him to maintain himself. In the past it has been advocated that the infant should be given boiled water for twenty-four hours and then 5%

lactose solution for the next twenty-four hours, actual food being withheld until he is two days old. This method is based on the analogy of the full-time infant, who is born equipped for a period of semi-starvation. Actually the premature infant is in a totally dissimilar condition. He has no reserve stores on which to draw, and if he is starved for forty-eight hours he loses condition rapidly, becomes increasingly difficult to feed, tends to develop œdema and hypothermia, and has his chances of survival seriously prejudiced. We therefore begin to feed these infants six hours after birth.

Routine Method of Feeding.

In an endeavour to steer a safe course between the dangers of overfeeding and those of underfeeding, the following routine method has been evolved and has been found satisfactory. It is of interest to note that since its adoption the number of infants suffering from attacks of cyanosis has been greatly decreased. It is probable, therefore, that attacks of cyanosis which were ascribed to an immature state of the respiratory centre were in reality, in many cases, due to aspiration of vomitus from an overfilled stomach. (This procedure did not, of course, affect the cyanosis occurring when the infants were very immature and on the borderline of viability.) Table I shows the amount of food given per day. The infant is

TABLE I.

Day of Life.	Ounces of Food per Pound of Body Weight per Day.
1	0·5
2	1·0
3	1·5
4	2·0
5	2·5
6 and after	3·0

fed every three hours day and night, receiving eight feeds per day; the amount per feed is therefore one-eighth of the total amount given in twenty-four hours. Thus the amount per feed of a baby weighing four pounds would be two drachms on the first day, four drachms on the second day, six drachms on the third day, one ounce on the fourth day, one ounce two drachms on the fifth day, and one and a half ounces on the sixth day. These amounts are tentative.

Aspiration of Gastric Residue.

When the gavage tube is passed for a feeding, and before the food is run into the stomach, a syringe is attached. Any residue from the previous feeding is withdrawn and the amount is measured. The next feeding is reduced by an amount equivalent to the residue obtained. For instance, if an infant has been given a feeding of six drachms and two drachms remain in the stomach, then the amount of the next feeding will be four drachms. If, as usually happens, there is no residue, one knows that the size of the feeding is safe. If the infant evinces signs of hunger some time before the feeding is due, the amount of food given can be increased above that set out in Table I.

The foods used are either breast milk, whenever it is at all possible, or an artificial food which yields reasonable nutritive value. Many foods given to premature infants are so low in caloric value that the infant cannot subsist on them. When the amount given has to be small, as in the case of the babies under discussion, it is necessary to use food having at least 20 Calories to the ounce. For an average premature infant weighing three or four pounds the food generally used is as follows:

Milk, 12 ounces.
Lactose, four tablespoonfuls (medicinal tablespoon, level, tightly packed).
Water, to 20 ounces.

The ingredients are all simmered together in a double boiler for twenty minutes and then brought up to the original volume with boiled water. For very immature infants mixtures containing less milk and more sugar can be utilized, for example:

Milk, 8·5 ounces.
Lactose, five tablespoonfuls and one teaspoonful.
Water, to 20 ounces.

or

Milk, 10·5 ounces.
Lactose, four tablespoonfuls and three teaspoonfuls.
Water, to 20 ounces.

Lactone syrup milk mixtures may also be employed in the following gradations:

First day:
Lactone syrup milk, 10 ounces.
Lactose, 6·5 teaspoonfuls.
Boiled water, to 20 ounces.

Second day:
Lactone syrup milk, 13·5 ounces.
Lactose, 2·5 teaspoonfuls.
Boiled water, to 20 ounces.

Third day:
All lactone syrup milk.

The theoretical objection may be raised that if infants are given the amounts outlined above they will not until the sixth day of life receive their full fluid requirement of three ounces per pound of body weight. Practically it is found that the infants progress satisfactorily, and I have not supplemented their fluid intake.

It is thought that the adoption of this simple measure—the routine aspiration of the stomach for residual food before the next feeding is given—will eliminate the danger of aspiration of food and help to lower the morbidity and mortality rates among premature infants.

Summary.

1. The danger in gavage feeding of premature infants of the aspiration of vomitus from too large a feeding is discussed.

2. A simple and satisfactory method of guarding against over-distension of the stomach is outlined.

3. A scheme of amounts per feed found to be safe for gavage feeding is given.

4. Some types of artificial food suitable for premature babies are given.

Reviews.

ANÆSTHETIC DRUGS AND THEIR PHARMACOLOGY.

"THE Pharmacology of Anesthetic Drugs", by John Adriani, is an interesting compilation of summarized data arranged in an unusual manner.[1]

Throughout the work information is presented in well-annotated diagrams indicating graphically the mechanisms of absorption, pharmacological action and elimination of various anæsthetic and hypnotic drugs. In many of these the author shows a happy combination of ingenuity and originality.

Appreciation is, however, somewhat blunted by his carrying the graphic representation to the point of tediousness, and though it is possible that, by a sort of summation of stimuli, the very monotony of such presentation may be impressive, it is easily provocative of mental dyspepsia.

The work contains a considerable volume of tabulated information ranging through chemistry and physiology to pharmacology, and essentials having a direct bearing on clinical application are stressed. Sections devoted to general aspects of absorption and elimination and of systemic effects in common form a sound introduction to monographs dealing

[1] "The Pharmacology of Anesthetic Drugs: A Syllabus for Students and Clinicians", by J. Adriani, M.D.; Second Edition; 1941. Springfield: Charles C. Thomas. Demy 4to, pp. 95, with illustrations. Price: $3.50 net.

with specific anæsthetics—general, local and spinal—and basal narcotics.

In addition to these, many non-anæsthetic drugs frequently used in conjunction with anæsthesia are efficiently reviewed. These include atropine and related drugs, the analeptic group and such gases as oxygen, carbon dioxide, nitrogen and helium.

Clinical considerations relating to pre-anæsthetic medication, complications and potential accidents during administration, and post-anæsthetic sequelæ are conveniently summarized.

In common with most "digests", the book exhales a challenging breath of dogmatism, which disposes easily of many controversial issues. The author, however, disarms potential acceptors of such a challenge by admitting that, when controversial matters are involved, he has reasonably exerted the right to emphasize his own conclusions from personal clinical experience. Despite this, one cannot but feel that in some instances the air of finality indicated on the charts is still a little in advance of actual pharmacological observation relating to the human subject.

Minor criticism notwithstanding, this book may be hailed as an excellent and comprehensive work which can be recommended with confidence for rapid and ready reference by either student or practitioner. Those entrusted with the teaching of this subject will find many an inspiration in the graphic method of presentation.

CONCERNING VITAMINS.

New books on vitamins must these days be subject to a certain amount of suspicion as just further additions to a rather crowded field. Professor Borsook's recent volume "Vitamins: What They Are and How They Can Benefit You"[1] sets something of a new standard and should take its place as one of the most authoritative and at the same time most popular works on this subject. While sacrificing nothing of scientific detail or accuracy, the author has made it possible for any intelligent person, with but little scientific knowledge, to follow his argument with ease and benefit.

In addition to the usual features of the subject of vitamins—the effects of deficiencies, the chemical nature of those already known, the sources—Professor Borsook introduces a considerable amount of unusual and interesting material. His historical outline includes some observations on the food of our ancestors, derived from the writings of first-hand observers. To this end are included quotations from Samuel Hartlib, Pepys, Disraeli, and in particular Arthur Young. This last-mentioned author, an agricultural theorist of some repute and an observant traveller, is deserving of considerable study by students of nutrition and food production policy.

The comparative nutritional aspects of the Scott and Amundsen expeditions to the South Pole show how greatly the success or failure of such undertakings depends on the supply of correct food. Further examples are to be found in the various expeditions to Mount Everest. It is interesting to read of the many ingenious methods for obtaining vitamins which have been adopted from time to time in the absence of normal sources of supply. The use of an infusion of pine needles as a preventive and cure of scurvy during the Alaska gold rush and the possibility of using the unusually high vitamin *C* content of hips and haws in England are mentioned, with a note that both methods are reported to be in use in the Union of Soviet Socialist Republics.

Commendable, further, is the stress laid on the widespread effects of mild vitamin deficiencies as opposed to gross deficiency diseases. This aspect of the matter is of recent development and presents one of the most difficult problems of nutrition. It is primarily a matter of public health policy; the fortification in Britain of white flour with vitamin B_1 and calcium is an important development, as is also the vitaminization of margarine. It would appear that in these matters British policy is somewhat ahead of American, although this is undoubtedly due to the pressure brought about by war-time conditions.

Borsook shows no sympathy with charlatans in the field of vitamins and nutrition. The laws of libel in America do not prevent one from stating the truth about commercial preparations, even if that would result in damage to the reputation of the product concerned. Hence such things as "vitaminized cosmetics", "vitaminized soaps", and a processed food advertised as containing "provitamin D" come in for some condemnation.

This book can be confidently recommended as an interesting and thoroughly practical addition to vitamin literature. It is well written, attractively set up, and remarkably cheap.

[1] "Vitamins, What They Are and How They Can Benefit You", by H. Borsook, Ph.D., M.D.; 1941. New York: The Viking Press; Sydney: Angus and Robertson Limited. Demy 8vo, pp. 225. Price: 12s. 6d.

THE NURSING AND DISEASES OF SICK CHILDREN.

THAT a third edition of "A Textbook on the Nursing and Diseases of Sick Children" is called for shows that it has proved its usefulness to the nurse.[1] In the present edition, which is fifty pages longer than the last, complete revision has been carried out and new methods of treatment are adequately described. In regard to meningococcal meningitis, the specific treatment by the use of antiserum is described in detail, while the use of the sulphonamide drugs is dismissed in a line or two. This paragraph has evidently not been revised in the present edition. When one considers the difficulties which must have been overcome in the revision of this book in these times of stress, it is perhaps excusable that such an omission should have occurred. The section on orthopædics has been enlarged from two chapters to three, and a new chapter by Lieutenant-Colonel E. H. Vere Hodge on the care of children in the tropics has been added. Miss Lewis supplies a useful appendix briefly describing methods of physical therapy.

The excellent illustrations have been increased from 112 in the second to 142 in the present edition. This new edition will no doubt enhance the already great popularity of the book among children's nurses.

STARLING'S PHYSIOLOGY.

FOR nearly thirty years Starling's "Principles" has been the standard English text-book of human physiology. Like the three which have appeared since Starling's death, the eighth edition has been prepared by C. Lovatt Evans.[2] Indeed Professor Evans has been intimately associated with the preparation of this book from its first (1912) edition, for which he compiled the index. The successive revisions which the book has undergone at his hands have been so thorough that he may now be considered more appropriately as the author than the editor. The incorporation of new material in new editions has been accompanied by judicious modification or rejection of old, so that the present edition, although it contains about 140 pages more than the seventh, is no bigger, but is more compact, than the first.

In this edition the principal change has been in the sections on the nervous system. The chapters on the central nervous system have been completely rewritten. The special senses are now treated in a separate section, which has been prepared, as in previous later editions, by H. Hartridge. The sections on reproduction and on the endocrine glands have also been subjected to considerable revision.

The illustrations have been revised with the same thoroughness as the text. Well over 100 additional illustrations are present, and many of the illustrations of the previous edition have been replaced by others.

This text-book emphasizes the principles rather than the applications of the subject; its value to the medical student can therefore hardly be over-estimated. Indeed, most graduates would be the better for frequent reference to it to refresh their knowledge of those principles the application of which should form so great a part of their daily work. A text-book like this should be in the hands of medical students from the beginning of their study of physiology at the university. It is a big book, but medical students should realize early that physiology is a big subject, and especially that it does not consist of two distinct parts, known respectively as "second year physiology" and "third year physiology". A big text-book may be apt to overwhelm and confuse the junior student. This tendency, however, can and should be overcome by guidance given in lectures as to reading, and by the use of a smaller text, of which there are several, to give a general view of the subject and to serve as a guide to, but not as a substitute for, the larger text-book in the early stages of the study of physiology.

[1] "A Textbook on the Nursing and Diseases of Sick Children", edited by A. Moncrieff, M.D., F.R.C.P.; Third Edition; 1941. London: H. K. Lewis and Company Limited. Demy 8vo, pp. 654, with 142 illustrations. Price: 21s. net.

[2] "Starling's Principles of Human Physiology", edited by C. L. Evans, D.Sc., F.R.C.P., F.R.S., LL.D., with chapters on the Special Senses revised by H. Hartridge, M.A., M.D., Sc.D., F.R.S.; Eighth Edition; 1941. London: J. and A. Churchill Limited. Royal 8vo, pp. 1,257, with 673 illustrations, 7 in colour. Price: 32s. net.

The Medical Journal of Australia

SATURDAY, JANUARY 17, 1942.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

Reference to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE FUTURE OF MEDICINE AS A "CULTURAL PROFESSION".

In these days when so much is heard of the future of medical practice and plans of different kinds are being made by persons with widely divergent ideas, some thought should be given to the future of medical education. Australian medical practitioners have read with interest the articles appearing in *The British Medical Journal* of September 6, 1941. In that journal Professor John A. Ryle writes on "The Future of Medical Education as seen by a Teacher". Mr. Donald McDonald, of Radcliff Infirmary, Oxford, gives a medical student's view of the future of medical education and both papers are discussed in a leading article. Professor Ryle's contribution, like most of his published views, is so clearly expressed and so logical, that it should be read by every Australian member of the British Medical Association. One of his statements seems to be of particular importance and to merit further inquiry. He writes that if there is one thing which medicine has shown a tendency to sacrifice in return for the rapid contribution of the sciences to its instruction and practice, it is perhaps its position as a cultural profession. Its philosophy, he adds, has not kept pace with technical achievement. He asks how medical education in the future shall help to develop a breed of doctors better blessed with humanity and judgement, with simultaneous gain rather than loss to their scientific sense. When Professor Ryle refers to medicine as a cultural profession he can mean only one of two things. Either the profession of medicine is one which of itself endows or can endow its practitioners with culture, or medicine is a profession of so peculiar a kind that its practice is most grateful to those who pursue it with cultured minds. By a cultured mind we mean a cultivated mind; we can therefore say that though the practice of medicine may open new fields to an intelligent and receptive mind, it is the cultivated mind, when applied to the whole field of medicine, that will, more than any other, reap in that field first the flower and then the full fruit of an abundant harvest. In a cultivated mind seeds of many kinds have been sown; variety of itself has helped to make the soil fertile, growth of one type making way time and again for growth of another, and each type requiring its own peculiar soil so that periods recur during which soil of each kind lies fallow. A mind given to the cultivation of one product only will in time surely yield a stunted product unless it is enriched from some outside source. If it is true that medicine is showing a tendency to sacrifice "its position as a cultural science", this tendency must be stopped, and it cannot be stopped unless the reasons for the tendency are known. Several possible reasons appear at once. The fault may lie in the mind itself or may arise outside the mind and affect it in several ways. Clearly the mind of a man or woman who essays the study of medicine may have no wide range of experience, knowledge or sympathy, having been handicapped from birth by growth in a sterile atmosphere. Again a mind, cultured, supple and luminous, may enter the field of medicine and even be eager and active, but from lack of care or from laziness become the slave of a dull routine and at last jog along at peace in the rut of its own creation. As already stated, the mind may be affected by outside conditions. The most potent of these is the speed of modern life—there is too much hurry, man is too anxious to see instant results, and he has an impatience bred of pride and vanity. Lastly the field of medicine is so wide that no one mind can do more than make a surface inquiry of the whole; as the search becomes deeper, the range must be restricted and it is easy to see how other interests may be crowded out of a busy life.

When all the tendencies mentioned may combine to make medicine sacrifice its position as a cultural profession, it is impossible to decide whether one is more responsible than another. To attribute the loss of culture to one factor alone is unwarranted and to make no effort to find a remedy would be typical of arm-chair criticism of the worst type. Professor Ryle deals with "some remedies" and urges the teaching of biology and elementary physiology in the school period and he also discusses the earlier years of the medical curriculum and makes suggestions; these in his opinion will obviate "cramming", which, he adds "succeeds only partially in the training of organized and inquisitive minds". There is a great deal of truth in all that Professor Ryle writes in this regard—we have on more than one occasion advocated the teaching of biology to all school children as one of the best possible ways of giving them a wide outlook on life and some of its problems—but it is possible by looking at the subject from one aspect only to come to conclusions that are pitifully misleading. In *The British Medical Journal* of September 20, 1941, a correspondent takes this matter up. He refers to a statement in the leading article of September 6 to the effect that 45% of university students are in receipt of State grants. He asks: "Is it not possible that the cultural degeneracy of which Prof. Ryle bears evidence may be an outcome of this profuse State aid to entry into the profession." He states that it must be obvious that a boy whose parents have the means to put a son to medicine will have more opportunity of exercising a choice of career than one whose career is determined by

obtaining a scholarship. Culture, he adds, is a process of slow and continuous growth from a very early age, largely dependent on many factors, such as environment, heredity *et cetera* involved in their education, and not necessarily associated with mere instruction and the possession of a good memory. These views stated in their bald simplicity arouse our ire. There is no doubt something in the correspondent's contention, but it does not, as his letter implies, tell the whole story. No sensible person in the present day will deny to the son of a poor man the right to enter one of the learned professions. We do not think that the correspondent in question meant to convey this impression, but we should have been gratified if he had done more than make his blunt suggestion. Cultivated minds are not the prerogative of the wealthy. If there are those who hold such a view, they would find a useful exercise in the study of satire and in the course of their study they might find themselves able to sing with the chorus of peers in "Iolanthe":

> Hearts just as pure and fair
> May beat in Belgrave Square
> As in the lowly air
> Of Seven Dials!

It is clear that a background of culture in the home is a great asset to a growing youth who is destined to enter the medical profession. If he has no such background, the obvious thing to do is to try to make good the deficiency. This must be done in early years of the school period and the effort must be continued until undergraduate days begin. By this time a foundation for future building should be laid. As a matter of fact in many schools in Australia pupils are being given one or two periods in the week during which they receive instruction in some branch of literature or the arts that has no immediate bearing on the passing of examinations or on what is likely to be their life's work in later years. Those who heard a broadcast on the national network in the latter part of last year by the headmaster of Geelong Grammar School on the subject of education will appreciate the value of this type of adventure in the life of school boys. It may be objected that intermittent tuition of this kind is not so effective as the constant and insensible direction that takes place in a cultured home. This is undoubtedly true, but it must be remembered that we are trying to find something that will fill a gap, not something that will be ideal. Further, boys often look on anything that savours of the artistic—music, for example—as something not quite manly, something not to be publicly acknowledged, but guarded as a secret. To have these things taught in open school and to see them obviously regarded as desirable by their school masters will surely dispel any tendency to furtiveness that may exist. Such school teaching may therefore be an advantage even to the boy who lives in a cultured family circle. This whole question has to do with a sense of values. In a discussion on this subject as long ago as 1935 we quoted Clive Bell who rightly insists that one of the great problems of humanity will be solved if boys and girls can be made to realize that the delight of being alone in a bed-sitting room with an alert, well-trained, well-stocked mind and a book is greater than that of owning yachts and race-horses, and that the thrill of a great picture or of a quartet by Mozart is keener than that of the first sip of champagne. The young can be taught the value of intangible things that are a stimulus to good living and high thinking, the things that are attributes of the cultured mind.

One aspect of this subject remains. Professor Ryle has referred to doctors who are "blessed with humanity and judgement", and *The British Medical Journal* correspondent to parents who have means "to put a son to medicine". If we admit that the man of culture is more likely to respond to the call of the human race sick from many causes—and the view is reasonable—we are entitled to ask whether the man of wealth whose parents have means to put him to medicine is as likely as his impecunious brother to understand and be willing to attempt to remedy the lot of those who are submerged in the struggle for existence, those who live from hand to mouth and who should be the first care of the medical hygienist. No one, unless he is specially gifted with understanding and sympathy, can appreciate what the struggle of the poor in the community means until he has himself been hard put to it to make both ends meet. Taking all the facts into consideration we can aver that humanity and judgement are just as likely, possibly more likely, to be found among those whose means are not sufficient to pay for their medical education as among those whose parents can pay. Readers must conclude this discussion for themselves, but we would suggest that the medical education of the future must begin in the early years of school life by the creation of wide interests in all that goes to make a full man in the true sense. The community must see that all its sons, rich or poor, are given the opportunity to equip themselves to serve their fellows in the fight against disease in all its forms.

Current Comment.

CHEMOTHERAPY IN VENEREAL DISEASE.

THE Federal Security Agency of the United States Public Health Service has recently issued a symposium entitled "The Newer Therapy of Venereal Diseases". As this publication is not generally available to Australian practitioners, a *résumé* of its more important features is given.

H. H. Young, H. C. Harrill, J. H. Semans and O. S. Culp, writing from the James Buchanan Brady Urological Institute of Johns Hopkins Hospital, report the results of the treatment of gonorrhœa with sulphanilamide and related drugs. During a three-year period these authors have treated with sulphanilamide a series of 300 dispensary patients. Of the 300 patients 93, or 31%, made only two initial visits to the dispensary and could not be traced further. Of the 93, however, 40 were free of discharge on their second visit. Ten patients received inadequate amounts of the drug on account of their poor cooperation. In 146, or 74%, of the remaining 197 cases an excellent result with cure was obtained in less than twenty days. Of the 146 infections 102 were confined to the anterior portion of the urethra and 24 included both the anterior and posterior portions. In these cases the discharge disappeared after an average of five days, although in twelve instances the discharge persisted for as long as sixteen days. In an additional 27 cases more than twenty days were required to effect a cure; in four of these the discharge persisted for more than thirty days. Eleven of these infections involved the posterior as well as the anterior portion of the urethra. In the remaining 24 of the 197 cases practically no response followed exhibition of the drug and they were regarded as failures. In 18 of these 24 cases branded as failures prostatitis was present in addition to anterior and posterior urethritis when the

patient was first seen; and in twelve cases sufficient amounts of the drug could not be given on account of reactions.

Young and his fellow workers are convinced of the great value of the drug. At least 80% of the patients were able to tolerate the drug with only minimal symptoms. The symptoms which included headache, dizziness, anorexia, nausea, vomiting, palpitation and cyanosis were present usually in proportion to the amount of the drug ingested. When these workers state that in their cases there were no serious reactions, they do not mean to imply that the drug is harmless; on the contrary extreme caution must be exercised in its administration, and the patients must be kept under observation. They are of the opinion that a large initial dose, 80 to 100 grains, approximately 0·008 to 0·1 gramme per kilogram of body weight, followed by increasing doses over a period of at least three weeks, is the most satisfactory method of treatment. Though 7% of the patients were apparently cured by small amounts of sulphanilamide totalling no more than 200 grains, and made only one or two visits to the dispensary because they seemed quite well, the view is expressed that most patients have a recurrence if the administration of the drug is stopped after such small doses and as soon as the discharge has disappeared. In only one respect is the information about these cases incomplete—there is no indication regarding the length of time that elapsed between the appearance of the discharge and the first administration of the drug. In some accounts of sulphanilamide therapy in gonorrhœa difference of opinion has been expressed about this point. We must conclude that in the present series the drug was given as soon as the patient came under treatment. Though these authors do not mention the point, it is interesting to recall that it has been observed that those patients who complain severely in the early stages of the illness of symptoms caused by the drug give the best response to treatment, and that those who do not respond to treatment have a greater tolerance to the drug. From this it has been concluded that minor toxic effects are a manifestation of a response to the drug and that this response exerts a curative action. It is, of course, a common experience that when suitably administered and adequate doses of sulphanilamide have failed to effect a cure, any subsequent course of administration is also likely to fail.

Young and his fellow workers refer to the use of sulphapyridine. This drug was given in sixteen cases to patients who had been unsuccessfully treated with sulphanilamide; they presented such serious complications as stricture, periurethral abscess, urinary fistula, prostatitis, vesiculitis and epididymitis. The dosage given amounted to 80 grains a day for two or three days and after that 40 grains a day; the dosage was always considered adequate. In these cases the discharge was reduced, but never quite disappeared, and gonococci were still present in smears or could be recovered in cultures.

These authors also report the use of sulphathiazole in the treatment of thirty-eight male patients; twenty-one have been followed since treatment was concluded. Seventeen have had no recurrence and appear cured; two frank failures and one recurrence have been noted. Most of the patients received one gramme of sulphathiazole every six hours, and the average duration of treatment was 9·3 days. The discharge disappeared on an average in 2·7 days in the uncomplicated and in 5·2 days in the complicated cases. Two of the patients who were cured had failed to respond to sulphanilamide. The group is admitted to be too small to allow sweeping conclusions to be drawn. The authors, however, state that the three drugs mentioned are of great value in the treatment of gonorrhœa and that the choice of drug used will depend largely on the condition of the patient and the reactions produced. Patients who fail to respond to sulphanilamide may sometimes be quickly cured with sulphapyridine, and sulphathiazole may be effective when the other two have failed. It seems probable, these authors think, that sulphathiazole will become the drug most highly favoured in the treatment of gonorrhœa and its complications.

Among the other articles in the symposium is one by R. R. Wolcott, J. F. Mahony and C. J. Van Slyke on sulphapyridine in the treatment of gonococcal infections. They studied two hundred male patients who suffered from gonococcal urethritis. The usual dosage for patients weighing 150 pounds was six grammes per day for two days, followed by three grammes a day for an additional four to six days. The daily amount was given in six equally divided doses at four-hour intervals. Apparent cures were obtained in 159 of the 200 cases. Symptoms rapidly subsided and discharge practically disappeared in an average of 2·5 days. The drug was as efficacious in the cure of early acute gonorrhœa as in the more chronic disease.

O. S. Culp and H. H. Young contribute an article on the value of sulphanilamide in gonorrhœal arthritis. Arthritic complications occur in approximately 2·5% of all cases of gonorrhœa and the results of treatment are more often than not far from satisfactory. Culp and Young treated 22 patients; seventeen had the disease in an acute form and these manifested amazing improvement. In the four subacute and one chronic case the results were less striking. Great care is needed in these cases; the blood count must be watched and transfusion may be necessary. Sufficient sulphanilamide must be given to maintain a blood level of ten milligrammes per hundred cubic centimetres.

The three remaining papers in the symposium deal with the sulphanilamide treatment of venereal lymphogranuloma and of chancroid.

PROFESSOR J. T. WILSON.

MANY senior medical graduates of the University of Sydney will rejoice to know that Professor J. T. Wilson has been honoured by the Anatomical Society of Great Britain and Ireland. Volume 76 of the *Journal of Anatomy* is dedicated to him. A biographical sketch of his career is published in the October, 1941, issue of that journal, and a photograph bearing his signature also appears. Professor Wilson, known as "Jummy" to all his students, came to Sydney in 1887 to become demonstrator of anatomy in the new medical school. In 1890 he became first professor of anatomy. Professor J. P. Hill, who writes the biographical sketch, was for many years in Sydney. He describes Professor Wilson's profound influence on the teaching of the Sydney school and on the important researches carried out within its walls in the early days. Among those who shared in this work were C. J. Martin, Almroth Wright, Grafton Elliot Smith, J. P. Hill, F. Tidswell and W. J. S. McKay. When in 1920 he "pulled up his roots and returned to the Motherland" as professor of anatomy in the University of Cambridge he set about the reorganization of the department and "within a remarkably short space of time he had created what amounted to a new Anatomy School". His interests naturally extended beyond the confines of his university and he became President of the Anatomical Society of Great Britain and Ireland. In 1909 he was elected Fellow of the Royal Society. Professor Hill quotes some remarks of Sir Mungo MacCallum which must be reproduced: "It has been said that the truly cultured man ought to know everything of something and something of everything; and few have approximated more nearly to that impossible definition than Professor Wilson." Professor Wilson's influence has been most profound on those whom he has taught. Among his old students who hold, or have held, important teaching posts in anatomy are numbered the late J. F. Flashman, the late John I. Hunter, the late Grafton Elliot Smith, A. N. Burkitt, R. A. Dart, W. A. Fell, Una Fielding, F. Goldby, H. L. H. H. Green, G. H. S. Lightoller, F. A. Maguire, F. P. Sandes, S. A. Smith and J. L. Shellshear. Outside the field of anatomy are many who, proud to have been his students, have grateful memories of his example and precept and would fain believe that they have reflected them in some degree in their own lives. Professor Wilson, now in his eighty-first year, has the good wishes as well as the high esteem and affectionate regard of many Australians.

Abstracts from Medical Literature.

PHYSIOLOGY.

Circulation in Rest and Work at High Altitudes.

E. ASMUSSEN AND FRANK C. CONSOLAZIO (*The American Journal of Physiology*, March, 1941) report the effects of a sojourn for two weeks at the summit of Mount Evans (14,000 feet). Two subjects were studied. In both subjects an increase in the resting cardiac output of about 100% occurred during the first four to five days, later followed by a return to values still well above sea-level values. The blood volume decreased considerably for the first three or four days, then increased to a level still below the sea-level values. The percentage oxygen capacity was increased already the first day, presumably as a result of withdrawal of fluid from the blood. Determinations of the total oxygen capacity showed that an increased formation of red cells first occurred after a latency of four to five days. In work the cardiac output was considerably higher during the first days than later on, but even then it was still higher than at sea level. The decline in cardiac output after about a week at high altitude is presumably related to the concomitant increase in blood volume and total oxygen capacity. The chemosensible reflexes were active during the whole sojourn at Mount Evans. If the acclimatized subjects breathed an air mixture enriched with oxygen, the cardiac output both in rest and during work fell to values lower than the corresponding sea-level values. The findings are discussed.

The Mechanism of Enhanced Diabetes with Inflammation.

V. MENKIN (*The American Journal of Physiology*, October, 1941) describes experiments which were made in an endeavour to explain the effect of infection or inflammation on human diabetics so well known to clinicians and pathologists. Dogs were used, and the pleural inflammation was produced by the intrapleural injection of 1·5 millilitres of turpentine. The author comes to the following conclusions. An acute pleural inflammation in a dog fails to alter its blood sugar level. On the other hand, the presence of an acute inflammatory reaction in a dog rendered diabetic by pancreatectomy, induces a rapid and marked elevation in the blood sugar level. The extent of local proteolysis at the site of an acute inflammation in a diabetic dog is considerably greater than that found in a non-diabetic animal. This is indicated by a lower concentration of the total proteins and a correspondingly higher concentration of urea, non-protein nitrogen and amino-acid nitrogen than is encountered in the exudative material of a non-diabetic animal. The enhanced protein catabolism in the inflamed area of a diabetic animal is correlated with a marked elevation in both exudate sugar and exudate lactic acid. Insulin administration not only reduces the level of sugar and lactic acid in such diabetic exudates, but this substance diminishes as well the degree of local proteolysis. This fact supports the view that gluconeogenesis at the site of an acute inflammation in a diabetic animal originates from proteins through deamination of the molecule. Enhanced local proteolysis in the inflamed area of a diabetic animal implies increased tissue damage. The cytological picture of a diabetic exudate indicates that polymorphonuclear leucocytes manifest pronounced signs of cellular injury when compared with similar cells derived from a normal exudate. The biochemical changes encountered in the exudate of a depancreatized dog are similarly reflected in its circulating blood. Besides an elevation in blood sugar level, there is also an increase in the blood concentration of non-protein nitrogen, urea and amino-acid nitrogen. Studies after pancreatectomy or splenectomy and a comparison of the relative glucose concentrations in exudate and blood indicate that the raised levels of the carbohydrate and nitrogenous constituents of the systemic circulation are due neither to the diabetes *per se* nor to the operative procedure. The elevation in the levels of these substances is referable to an absorption from the area of acute inflammation which complicates the diabetic disorder. Insulin, by inhibiting glucose formation in the inflamed area, likewise prevents a rise in the blood stream of intermediary products of carbohydrate and protein metabolism. The available evidences, therefore, support the view that the mechanism of enhanced diabetes with concomitant inflammation might well be referable primarily to an increased local proteolysis in the inflamed area, favouring a combined picture of increased tissue damage with a corresponding elevation in glucose formation; the glucose in turn gradually diffuses into the systemic circulation.

Chemical Temperature Regulation.

A. HEMINGWAY AND S. R. HATHAWAY (*The American Journal of Physiology*, October, 1941) describe experiments which indicate that of the two possible components of chemical temperature regulation, the effect of shivering on metabolism is far greater than any possible effect due to the action of hormones in stimulating energy metabolism. The oxygen consumption rate and carbon dioxide production of three trained dogs have been measured while the animals were slowly cooled in an electrically shielded metabolism chamber. The onset of shivering was noted by electrical, mechanical and visual methods. In the electrical method the action currents were picked up by small skin electrodes placed over shivering muscles. The action potentials were amplified and made to operate a loud speaker, a cathode ray oscilloscope and a recording electronic integrator. On cooling before shivering started there was an average increase of metabolic rate of 7% over basal level. During the first twenty minutes of shivering the increase over basal level was 30%. These results indicate that the increase of metabolic rate without shivering has little effect in combating exposure to cold.

Tolerance of the Newborn to Anoxia.

J. F. FAZEKAS, F. A. D. ALEXANDER AND H. E. HIMWICH (*The American Journal of Physiology*, September, 1941) made a comparative study of the tolerance of the newborn and adult animal to oxygen lack produced by partial or complete replacement of oxygen of the inspired air by nitrogen, and by the respiration of pure helium, nitrous oxide, cyclopropane or carbon dioxide and by submersion in water. The newborn exhibit an extraordinary tolerance in comparison with the mature animal of the same species. For instance, a day-old rat survived for fifty minutes in an atmosphere of nitrogen, whereas the adult animal succumbed in one and a half minutes. The period of tolerance, however, is not the same in the various species studied, being longest in the physiologically immature newborn rat and shortest in the comparatively mature guinea-pig. Blood studies reveal that newborn dogs survive despite the fact that their arterial blood contains practically no oxygen after the first few minutes of anoxia. Among the factors permitting survival of the newborn rat and puppy is poikilothermia, a fall of temperature diminishing the metabolic demands. Another factor is the lower cerebral metabolic rate demonstrated in the rat and dog. Fœtuses delivered from mothers who had succumbed to anoxia produced by inhalation of 5% oxygen in nitrous oxide or the injection of cyanide, respired spontaneously on delivery, and some were raised by foster-mothers.

The Pancreatic Secretagogue Action of Products of Protein Digestion.

J. E. THOMAS AND J. O. CRIDER (*The American Journal of Physiology*, October, 1941) discuss the confusing statements which occur in the literature concerning the effect of various stimulations on the secretion of pancreatic juice. Experiments were then undertaken in an effort to clarify the position. The results indicate that the products of protein digestion act in the intestine as stimuli for the external secretory function of the pancreas. Their effectiveness is not dependent on the coincident flow of bile into the intestine nor on the secretagogue action of water or acid. The secretion produced by peptone stimulation has a higher specific gravity and contains many times more nitrogen per cubic centimetre than that produced by water, acid or secretin. There are among various commercial peptones and protein digests prepared in the laboratory wide variations in effectiveness as stimuli for the pancreas. Among commercial peptones the more effective products are those having the higher percentage of proteose. The properties of the secretion are such that it could not be produced by secretin stimulation alone. The secretion elicited by peptones resembles that caused by pilocarpine and other stimuli acting through or on the secretory nerves. Hence the conclusion is drawn that the peptones act through a nervous mechanism.

Thyreoid Activity after Iodine Ingestion.

G. C. RING (*The American Journal of Physiology*, October, 1941) describes experiments carried out with rats in an effort to find some support for the common procedure of administering iodine to hyperthyreoid patients in order to depress the activity of the thyreoid before operation. The authors found that when rats kept in a refrigerator for three weeks are given 20 to 25 milligrammes of sodium iodide per day, an elevation in basal metabolism occurs which is as great as that found in control rats. After these rats have been placed in a warm environment their metabolism returns to the control level more quickly if they are given sodium iodide. The ingestion of sodium iodide does not depress the metabolism of normal rats unless the amount given

is large enough to cause inanition. The withdrawal of large doses of sodium iodide (in most cases 160 milligrammes per day) frequently depresses basal metabolism for several weeks thereafter. The withdrawal of smaller doses of sodium iodide (20 to 25 milligrammes per day) does not bring about a measurable reduction in metabolism. It does prevent the occurrence of as large an elevation of metabolism as that ordinarily produced by either thyreotropic principle or prolonged exposure to cold. When thyreotropic principle is given and followed by prolonged exposure to cold, the metabolic response is greater than that produced by either stimulus alone.

BIOLOGICAL CHEMISTRY.

Oral Lesions and Dietary Deficiencies.

O. D. CHAPMAN AND A. E. HARRIS (*The Journal of Infectious Disease*, July-August, 1941) have investigated the effect of various vitamin deficiencies on the development of oral lesions, especially gingivitis, in monkeys. Rhesus monkeys (*Macacus mulatta*) were used because their dental formula resembles that of man and because they are susceptible to vitamin *C* deficiency. Particular attention was paid to the occurrence and development of fusiform bacilli and spirochætal flora. Monkeys maintained on an adequate diet had normal mouths, while those on deficient diets had a tendency to develop oral lesions accompanied by an increase in the numbers of fusiform bacilli and spirochætes. The effects of deficiencies of vitamin *C*, nicotinic acid, riboflavine and filtrate factor are described. Normal monkeys on adequate diets resisted artificial implantation of fusiform bacilli and spirochætes under severe test conditions.

Gramicidin.

R. D. HOTCHKISS AND R. J. DUBOS (*The Journal of Biological Chemistry*, October, 1941) have reported improved methods for the isolation of tyrothricin from peptone cultures of *Bacillus brevis* and the separation from this substance of its components gramicidin and tyrocidine. These substances had been shown to possess marked bactericidal activity for Gram-positive microorganisms. Some of the chemical characteristics of the two substances are described.

R. D. HOTCHKISS AND H. N. CHRISTENSEN, R. R. EDWARDS AND H. D. PIERSMA (*ibidem*) report further details of the chemical structure of gramicidin and tyrocidine. It is shown that both substances are polypeptides. The amino acids present have been listed.

F. LIPMANN, R. D. HOTCHKISS AND R. J. DUBOS (*ibidem*) have shown by means of enzymatic assay with d-amino acid oxidase that 45% of the a-amino acids of gramicidin have the d-configuration. Tyrocidine contained about 20% of its a-amino acids in the d-amino acid form.

M. TISHLER, J. L. STOKES, N. R. TRENNER AND J. B. CONN (*ibidem*) give further details of the chemical properties of gramicidin. The molecular weight of gramicidin presented an anomaly in that it appeared to depend on the nature of the solvent and the concentration of the solute. Cryoscopic determination in cyclohexanone gave values from 600 to 1,200, whereas isothermal distillation in methanol indicated a molecular weight of 3,100. Chemical analysis of the crystalline flavianate derivative gave a molecular weight of 3,000.

W. E. HERRELL AND D. KEILMAN (*Journal of Clinical Investigation*, September, 1941) have tested, experimentally and clinically, the properties of tyrothricin, gramicidin and tyrocidine. The bactericidal effects were tested by use of a tissue culture technique. Tyrothricin was used locally in twelve cases of various types of infections in which Gram-positive bacteria were present. Marked beneficial effect was noted in most cases. No evidence of toxicity was observed under the conditions of treatment employed. Gramicidin was shown to possess powerful hæmolytic action on erythrocytes *in vitro*.

Myohæmoglobinuria.

C. L. YUILE AND W. F. CLARK (*The Journal of Experimental Medicine*, September, 1941) have shown that when myohæmoglobin was injected intravenously into dogs in amounts ranging from 0·75 to 1·0 gramme, it was rapidly eliminated from the plasma and approximately 65% was excreted by the kidneys in from one and a half to two and a half hours. Myohæmoglobin did not appear in the urine below a threshold plasma concentration which was slightly under 20 milligrammes per 100 cubic centimetres, but above this level the rate of renal excretion was directly proportional to the plasma concentration. The maximum myohæmoglobin/creatinine clearance ratio averaged 0·58, in contrast with a value of 0·023 for blood hæmoglobin. This indicated that the rate of renal clearance of myohæmoglobin was twenty-five times more rapid than that of blood hæmoglobin. The evidence suggested that the excretory mechanism was essentially similar for the two substances, but that differences in the molecular weight accounted for different rates of glomerular filtration.

Dietary Treatment of Cirrhosis of the Liver.

A. J. PATEK, JUNIOR, AND J. POST (*Journal of Clinical Investigation*, September, 1941) have shown from studies extending over a period of four years that the treatment of cirrhosis of the liver by a highly nutritious diet supplemented with vitamin *B* concentrates is of therapeutic value. A series of 54 patients so treated was compared with a control series of 386 patients with cirrhosis of the liver. In addition to an increased period of survival, there were signs of general bodily improvement and presumptive evidence of arrest of the disease process. In a significant number of patients there was disappearance of ascites, œdema, jaundice and of vascular "spiders". Certain laboratory tests also reflected corresponding improvement. The coexistence of nutritional deficiency and cirrhosis of the liver was striking. Although the relation of nutritional deficiency to cirrhosis was not clear, the clinical observations suggested that nutritional deficiency predisposed to the development of cirrhosis and that this, once established, tended to perpetuate the state of nutritional deficiency.

Acute Hæmolytic Anæmia in Sulphonamide Therapy.

C. L. FOX AND R. OTTENBERG (*Journal of Clinical Investigation*, September, 1941) have studied four cases of acute hæmolytic anæmia during therapy with sulphanilamide and sulphapyridine. The pigments in the erythrocytes, serum and urine were examined spectrophotometrically. The red cells which survived hæmolysis were essentially normal, containing little methæmoglobin or sulphæmoglobin. The serum twelve to forty-eight hours after the onset of hæmolysis contained 0·4 to 1·7 grammes per 100 millilitres of three blood pigments: hæmoglobin, methæmoglobin and methæmalbumin; no sulphæmoglobin was present. Approximate calculations indicated that about 500 to 700 grammes of hæmoglobin were liberated in these "explosive" hæmoglobinæmias. After twelve to forty-eight hours only small amounts of pigment remained in the plasma, while less than 4% of the liberated hæmoglobin was excreted in the urine; most of the pigment had therefore been rapidly removed from the plasma by the liver, spleen and other tissues. The actual cause of the hæmolysis was not determined, but the possible mechanism of hæmolysis, the disposal of hæmoglobin and the cause of death are discussed in detail.

Permeability of Glomerular Membranes to Protein.

P. A. BOTT AND A. N. RICHARDS (*The Journal of Biological Chemistry*, October, 1941) have conducted a large number of experiments on amphibia to determine the extent of permeability of the glomerular membranes to small protein molecules. The glomerular membrane was found to be partially permeable to each of the proteins of the 35,200 molecular weight group, although differences existed between the extents of this permeability toward the various proteins. Purified protein derivative from tuberculin, with molecular weight of 14,500, was filtered more completely than the proteins of the 35,200 molecular weight group. The evidence suggested that most of the mesh surface of the glomerular membranes was coarse enough to permit the passage of particles about 20 Ångström units in diameter, and that only half of it allowed particles of about 50 Ångström units to pass through. Permeability of the membranes to proteins appeared to be grossly according to size of particles, but there was a possibility that other factors influenced the relative permeability towards particles of approximately the same size.

Insulin and Ketone Formation.

MICHAEL SOMOGYI (*The Journal of Biological Chemistry*, October, 1941) has shown, by experimental and clinical studies, that insulin exerts two opposite effects upon the level of blood ketones: for some time after injection it causes a decrease, but after protracted hypoglycæmia it produces a rise in blood ketone. Both these effects of insulin occurred in normal men and dogs as well as in diabetic patients and dogs from which the pancreas had been removed, but the magnitude of the effects is greater in the latter. Attention is drawn to systems of treatment of diabetic patients which are capable of producing prolonged periods of mild hypoglycæmia, especially during the night. The two-phase effect of insulin on the rate of formation of ketone bodies in the liver closely parallels the effect of insulin on the rate of hepatic glycogenolysis: in the first phase glycogenolysis is inhibited and the rate of ketone formation decreases; after persistence of hypoglycæmia for some time glycogenolysis is stimulated and the rate of ketone formation increases.

British Medical Association News.

ANNUAL MEETING.

THE annual meeting of the Victorian Branch of the British Medical Association and of the Medical Society of Victoria was held at the Medical Society Hall, East Melbourne, on December 3, 1941, DR. H. C. COLVILLE in the chair.

ABSENCE OF THE PRESIDENT.

DR. H. C. COLVILLE said that Lieutenant-Colonel A. E. Coates had returned unexpectedly from active service abroad a few weeks previously and there was rejoicing at the fact that he would read his president's address in person. However, Lieutenant-Colonel Coates had been recalled unexpectedly and had asked Dr. Colville to take the chair and read his address.

DEATH OF MEMBERS ON ACTIVE SERVICE.

The Medical Secretary read the names of seven members of the Branch who had died on active service during the year 1941: Major Eric Bailhache, Major John Ferguson Chambers, Surgeon Lieutenant Commander Francis Harrison Genge, Surgeon Commander John Reid Hasker, Captain John Colin Ramsay Joyce, Major Zelman Schwartz, Captain Stewart Irvine Weir. Members stood in silence as a tribute to their memory.

ELECTION OF OFFICE BEARERS AND MEMBERS OF COUNCIL.

The Medical Secretary announced that the Council had elected the following office-bearers.

President: Dr. H. Boyd Graham.

Senior Vice-President: Dr. J. A. Cahill.

Junior Vice-President: Dr. D. Roseby.

Chairman of Council: Dr. H. C. Colville.

Honorary Treasurer: Dr. C. H. Mollison.

Honorary Secretary: Professor R. Marshall Allan.

Honorary Librarian: Dr. R. H. Fetherston.

The Medical Secretary announced that the following had been elected members of the Council by the general body of the members: Professor R. Marshall Allan, Dr. Arthur Brown, Dr. Charles Byrne, Dr. H. C. Colville, Dr. John Dale, Dr. D. M. Embelton, Dr. John H. Gowland, Dr. John S. Green, Dr. Euan I. Littlejohn, Professor P. MacCallum, Dr. F. Kingsley Norris, Dr. David Roseby, Dr. Kenneth Smith, Dr. D. J. Thomas.

The Medical Secretary announced that the following had been elected by the subdivisions: Dr. A. E. Coates, Dr. Henry Searby, Dr. H. Boyd Graham, Dr. D. C. Lear, Dr. F. E. McAree, Dr. J. A. Cahill, Dr. M. H. Box, Dr. B. D. Fethers, Dr. Roy Watson, Dr. E. Ettelson, Dr. J. H. Paterson, Dr. F. J. Bonnin, Dr. G. A. Waterhouse, Dr. F. W. Grutzner, Dr. D. A. Carter, Dr. P. Goodman, Dr. W. Sloss, Dr. E. C. Varley.

The Medical Secretary announced that Dr. F. L. Davies, Dr. R. H. Fetherston, Dr. C. H. Mollison, Dr. J. Newman Morris and Dr. J. P. Major were the *ex officio* members of the Council.

The representative of the Victorian Medical Women's Society was Dr. Eileen FitzGerald.

ANNUAL REPORT OF THE COUNCIL.

On the motion of Sir James Barrett, seconded by Dr. A. E. Rowden White, the report of the Council, which had been circulated among members, was taken as read. On the motion of Dr. Kenneth Smith, seconded by Sir James Barrett, the report was adopted. The report is as follows:

The Council of the Branch and the Committee of the Society present the sixty-second annual report of the Branch and the eighty-sixth of the Society.

Election.

At the annual meeting held last December the following members of the Council and of the Committee were elected: Professor R. Marshall Allan, Dr. Charles Byrne, Dr. H. C. Colville, Dr. John Dale, Dr. D. M. Embelton, Dr. John H. Gowland, Dr. John S. Green, Dr. M. O. Kent Hughes, Professor P. MacCallum, Dr. L. A. Neal, Dr. F. Kingsley Norris, Dr. D. Roseby, Dr. Kenneth Smith, Dr. Douglas Thomas.

The following were elected to represent the subdivisions: Dr. G. Winter Ashton, Dr. F. J. Bonnin, Dr. M. H. Box, Dr. John Cahill, Dr. D. A. Carter, Dr. A. E. Coates, Dr. B. D. Fethers, Dr. P. Goodman, Dr. H. Boyd Graham, Dr. F. W. Grutzner, Dr. J. J. Kelly, Dr. D. C. Lear, Dr. F. E. McAree, Dr. J. Morlet, Dr. J. H. Paterson, Dr. Henry Searby, Dr. William Sloss, Dr. G. Raleigh Weigall.

Under Rule 9 the Council elected Dr. Eileen FitzGerald, nominated by the Victorian Medical Women's Society.

The following are *ex officio* members: The Trustees of the Medical Society of Victoria, Dr. F. L. Davies, Dr. R. H. Fetherston, Dr. C. H. Mollison, Dr. J. Newman Morris, and the representative of the Australasian Medical Publishing Company, Dr. J. P. Major.

The Council coopted at its first meeting Dr. Euan I. Littlejohn, a member, and, later in the year, Dr. Arthur Brown. Dr. E. Ettelson was appointed representative of the Southern Suburban Subdivision *vice* Dr. G. Raleigh Weigall.

The Council elected the following office bearers:

President: Dr. A. E. Coates.

Vice-Presidents: Dr. H. Boyd Graham and Dr. J. A. Cahill.

Chairman of Council: Dr. H. C. Colville.

Honorary Secretary: Dr. G. Winter Ashton.

Honorary Treasurer: Dr. C. H. Mollison.

Honorary Librarian: Dr. R. H. Fetherston.

The Executive consisted of the President and other office bearers.

On the appointment of Lieutenant-Colonel A. E. Coates to the Australian Imperial Force, Dr. H. Boyd Graham became Acting President.

Attendances at Council Meetings.

Eleven ordinary meetings and three special meetings of the Council were held. The following shows the attendances:

Dr. F. L. Davies	14	Dr. John S. Green	9
Dr. H. Boyd Graham	14	Dr. D. C. Lear	9
Dr. M. O. Kent Hughes	13	Dr. C. H. Mollison	9
Dr. F. E. McAree	13	Dr. J. H. Paterson	9
Dr. D. Roseby	13	Dr. C. H. C. Searby	9
Dr. K. Smith	13	Dr. L. A. Neal	8
Prof. R. Marshall Allan	12	Dr. Euan I. Littlejohn	8
Dr. M. H. Box	12	Dr. P. Goodman	7
Dr. Charles Byrne	12	Dr. J. J. Kelly	7
Dr. J. A. Cahill	12	Dr. J. Newman Morris	6
Dr. D. A. Carter	12	Dr. A. Brown[1]	5
Dr. H. C. Colville	12	Dr. A. E. Coates[2]	4
Dr. J. Dale	12	Dr. J. P. Major[2]	4
Dr. J. H. Gowland	12	Dr. E. Ettelson[1]	4
Dr. G. Winter Ashton	11	Dr. J. Morlet[2]	2
Dr. D. M. Embelton	11	Dr. F. J. Bonnin	1
Dr. B. D. Fethers	11	Dr. F. W. Grutzner	1
Dr. R. H. Fetherston	11	Dr. W. Sloss	1
Dr. Eileen FitzGerald	11	Dr. D. J. Thomas[2]	1
Prof. P. MacCallum	10	Dr. F. Kingsley Norris[2]	0
Dr. G. Raleigh Weigall[2]	10		

The highest attendance at any one meeting was 31, and the average attendance was 25.

Appointment of Subcommittees.

The following subcommittees were appointed by the Council (the first named acting as convener of that subcommittee):

Ethics.—Dr. Major, Dr. Davies, Dr. Green, Dr. Morris and Professor Marshall Allan, and the Executive. (Dr. Smith was appointed *vice* Dr. Major, Australian Imperial Force.)

Finance, House and Library.—Dr. Mollison, Dr. Fetherston and Dr. Major. (Dr. Smith was appointed *vice* Dr. Major, Australian Imperial Force.)

Legislative.—Dr. Davies, Dr. Ashton, Dr. Colville, Dr. Dale, Dr. Gowland, Dr. Green, Dr. Littlejohn and Professor Marshall Allan.

Organization.—Dr. Cahill, Dr. Ashton, Dr. Box, Dr. Byrne, Dr. Dale, Dr. Fethers. Dr. FitzGerald, Dr. Gowland, Dr. Green, Dr. Hughes, Dr. Lear, Dr. Littlejohn, Dr. McAree, Dr. Neal, Dr. Smith, Dr. Weigall (Dr. Ettelson was appointed *vice* Dr. Weigall, Australian Imperial Force), and representatives of country subdivisions.

Science.—Professors MacCallum and Marshall Allan, Dr. Graham, Dr. McAree and Dr. Searby.

Hospital.—Dr. Smith, Dr. Colville, Dr. Embelton, Dr. Graham and Dr. Weigall. (Dr. Ettelson was appointed *vice* Dr. Weigall, Australian Imperial Force.)

[1] Appointed during the year.
[2] Australian Imperial Force.

Correspondence.—Dr. Colville and Dr. Ashton.
Social.—Dr. Roseby, Dr. Ashton and Dr. McAree.
Workers' Compensation.—Dr. Smith, Dr. Ashton, Dr. Byrne, Dr. Colville and Dr. Searby.
War Emergency.—Dr. McAree, Dr. Gowland, Dr. Hughes, Dr. Lear and Dr. Littlejohn.

Special Standing Committees.

Early Medical History.—Dr. Black, Dr. Fetherston, Dr. Heffernan, Dr. Kenny, Dr. C. Macdonald, Dr. E. A. Mackay and Dr. Norris.
Yallourn.—Dr. Davies, Dr. Major, Dr. Morris, Dr. A. Robertson, Dr. B. M. Sutherland, Dr. Gerald Weigall, Dr. Zwar, and Medical Secretary *ex officio*.
Insurance Adjudication.—Dr. Major, Dr. Quick (acting in place of Sir Alan Newton) and Dr. Roseby.
Joint Insurance Adjudication.—Dr. Searby, Dr. R. C. Brown and Dr. Roseby.

Appointments and Nominations.

Trustees of the Medical Society of Victoria.—Dr. Davies, Dr. Fetherston, Dr. Mollison and Dr. Morris.
Central Council, British Medical Association.—Dr. Isaac Jones.
Federal Council.—Dr. Colville and Dr. Davies.
British Medical Agency Company of Victoria Proprietary Limited.—Directors: Dr. Mollison (Chairman) and Dr. Fetherston; Managing Director, Mr. W. Ramsay.
British Medical Insurance Company of Victoria.—Dr. Mollison (Chairman), Dr. Fetherston, Dr. Hurley, Dr. Morris, Dr. Norris; Secretary, Mr. J. M. Ford.
Victorian Correspondent, "The Medical Journal of Australia".—Dr. Graham.
Victorian Correspondent, "The British Medical Journal".—Dr. Graham.
Victorian Bush Nursing Association.—Dr. Graham and Dr. B. M. Sutherland.
Hospital Benefits Association.—Dr. Cahill, Dr. Dickson, Dr. Roseby and Dr. Graham (*vice* Dr. Norris, Australian Imperial Force).
Medical Eye Service of Victoria.—Dr. Gardner.
Ear, Nose and Throat Service of Victoria.—Dr. G. W. Ashton.
The Advisory Committee to the Charities Board.—Dr. Hurley, Dr. Embelton, Dr. Latham, Dr. Morris, Dr. McPhee, Dr. Zwar.
Electoral Board, Medical Staffing of Base Hospitals.—Dr. Major and Dr. Colville (*vice* Dr. F. K. Norris, Australian Imperial Force).
Free Kindergarten Union.—Dr. Gerald Weigall.
Victorian Baby Health Centres' Association.—Dr. Graham.
Melbourne University Union—Graduates' Section (formerly Melbourne University Association).—Dr. Stephens.
Victorian Institute of Hospital Almoners.—Dr. Morris.
Lord Mayor's Fund.—Dr. Morris.
Medical Advisory Committee, Education Department.—Dr. Zwar.
Victorian Council for Mental Hygiene.—Dr. Dale and Dr. Graham (*vice* Dr. Derham, Australian Imperial Force).
Melbourne Permanent Post-Graduate Committee.—Dr. Coates, Dr. Major and Dr. B. M. Sutherland.
Big Brother Movement.—Dr. Gerald Weigall.
The Society for the Health of Women and Children.—Dr. Gowland.
Medical Officers' Relief Fund, Advisory Committee.—Dr. Mollison, Dr. Davies and Dr. Upjohn.
Australian Aerial Medical Services.—Dr. Morris.
Nurses' Board.—Professor Marshall Allan, Dr. Hembrow.
Dietetic Association of Victoria.—Dr. Dale.
Society for Crippled Children.—Dr. Graham.
Victorian Council for Social Training.—Dr. Maudsley, Executive; Dr. Embelton, Council.
Anti-Cancer Council of Victoria.—Dr. Searby (*vice* Dr. A. E. Coates, Australian Imperial Force); Medical and Scientific Committee, Dr. Hurley.
Opticians' Registration Board.—Dr. E. L. Gault and Dr. A. Joyce.
City Electoral Roll.—Dr. Mollison.
Masseurs' Registration Board.—Dr. D. O. Brown and Dr. Hembrow.
National Safety Council of Australia.—Professor Osborne.
State Medical Coordination Committee.—Dr. Graham and Dr. Dickson (Medical Secretary).
Contract Practice Subcommittee, Federal.—Dr. Dickson.
Trustees, Income Insurance Fund.—Dr. Mollison, Dr. Davies, Dr. Fetherston, Dr. Major and Dr. B. M. Sutherland.

Branch Convocation.

The following were elected for the year 1941.—*Central*: Sir James Barrett, Dr. L. B. Cox, Dr. S. O. Cowen, Dr. K. D. Fairley, Dr. K. Hiller, Dr. G. R. A. Syme, Dr. M. D. Silberberg, Dr. G. A. Pennington, Dr. H. C. Trumble, Dr. Guy Springthorpe, Dr. B. T. Zwar; *Northern Suburban*: Dr. John O'Keefe, Dr. E. R. Cordner, Dr. S. L. Fredman, Dr. W. G. G. Sinclair; *Eastern Suburban*: Dr. E. M. H. Inglis, Dr. W. L. Carrington, Dr. R. W. Fisher, Dr. R. L. Forsyth, Dr. L. P. Wait; *Western Suburban*: Dr. G. Robinson and Dr. M. J. Costelloe; *Southern Suburban*: Dr. S. G. L. Catchlove, Dr. T. O. Sayle, Dr. A. J. Carroll; *South Central Suburban*: Dr. H. Grover, Dr. R. D. Aitchison, Dr. R. L. Park; *North Eastern Suburban*: Dr. M. Ashkanasy and Dr. K. Rush; *South Eastern Suburban*: Dr. G. E. Foreman, Dr. W. McLaren, Dr. R. M. Shaw, Dr. W. E. Tulloh; *Bendigo*: Dr. A. A. Crookes, Dr. E. Sandner, Dr. W. R. Groves; *Geelong*: Dr. R. L. Fulton and Dr. R. G. McPhee; *Ballarat*: Dr. Norman Longden and Dr. Chas. Richardson; *South Western Country*: Dr. W. Angus and Dr. K. F. O'Donnell; *Gippsland*: Dr. C. E. Willing and Dr. J. M. Andrew; *North Western Country*: Dr. G. Forsyth and Dr. G. R. Felstead; *North Eastern Country*: Dr. G. A. Waterhouse; *Goulburn*: Dr. A. L. Bennett (since deceased).

No meeting of Convocation was held.

Membership Roll.

The number of members on the roll at October 31, 1941, was 1,467, which is the same number as last year. Ninety-three names were added (67 by election, 8 who paid arrears, and 18 by transfer into the Branch), and 93 names were removed (21 by death, 12 by resignation, 20 by transfer out of the Branch, and 40 who allowed their subscriptions to fall into arrears).

Honorary medical members now number 39, six having been added and four having died.

Honorary student medical members number 9.

Death of the following members and former members is recorded with regret: Dr. B. J. Adam, Dr. Allan J. Bothamley, Dr. W. H. Coutie, Dr. I. H. Cowling, Dr. S. A. Ewing, Dr. F. C. Burke Gaffney, Dr. A. S. Grimwade, Dr. Yakoff Gorr, Dr. C. H. W. Hardy, Dr. L. G. Hayden, Dr. R. H. Hill, Dr. W. Kent Hughes, Dr. J. F. Joyce, Dr. R. J. Loosli, Dr. W. H. Lording, Dr. C. H. Martin, Dr. R. W. Miller, Dr. R. H. Morrison, Dr. A. W. Nankervis, Dr. J. J. O'Neill, Dr. W. J. Penfold, Dr. J. K. Richards, Dr. E. A. Spowers, Dr. C. E. Watson, Dr. H. J. Williams, Dr. F. Aldersley Wood and Sir Stanley Argyle.

Roll of Honour.

Died on Service Abroad.

Major Eric Bailhache, Major J. F. Chambers, Captain J. C. R. Joyce, Major Z. Schwartz, Captain S. I. Weir.

Members Serving in the Forces.

In addition to many member of the Branch engaged part-time in the services, the following are on full-time duty with the Navy, Army or Air Force: T. H. Ackland, J. K. Adey, J. M. Agar, A. J. W. Ahern, A. Alcock, R. J. Aitchison, J. F. Ackeroyd, D. G. Alsop, H. A. A. Altmann, A. Amies, B. H. Anderson, R. R. Andrew, H. L. Andrews, T. C. Anthony, S. T. Appleford, G. B. Baldwin, L. H. Ball, J. R. Bell, P. J. Benjamin, C. B. Berryman, D. J. Biddle, J. M. Blair, R. Blaubaum, J. H. Bolton, R. P. Booth, J. S. Bothroyd, W. M. Borland, V. Brand, V. B. Brenton, V. G. Bristow, R. C. E. Brodie, D. M. Brown, J. G. Brown, D. Officer Brown, K. B. Brown, D. D. Browne, K. B. Burnside, G. C. Burston, J. F. J. Cade, F. J. Cahill, I. T. Cameron, A. J. Campbell, H. I. Carlile, W. J. Carr, J. Catarinich, junior, E. T. Cato, C. K. Churches, E. Clarke, J. E. Clarke, A. E. Coates, J. H. Colebatch, G. B. Colquhoun, J. B. Colquhoun, W. L. Colquhoun, E. L. Cooper, W. D. Counsell, S. Crawcour, T. P. Crankshaw, W. F. H. Crick, E. R. Crisp, I. H. Cuming, E. A. Daley, L. Darby, R. B. Davis, A. P. Derham, A. E. Dickmann, H. C. Disher, A. J. M. Dobson, S. Donald, R. M. Downes, E. Downie, J. H. Downing, D. G. Duffy, W. J. L. Duncan, D. J. M. Dunn, R. H. L. Dunn, H. H. Eddey, E. R. Edwards, R. K. Edwards, A. S. Ellis, F. Ward Farmer, A. A. Ferris, E. W. Field, R. W. D. Fisher, W. L. Forsyth, S. E. Francis, A. N. Fraser, J. N. Freedman, N. F. Freemantle, J. L. Frew, H. G. Furnell, J. K. Gabriel, J. K. Gardner, D. R. Gauld, H. W. Gault, F. H. Genge, J. E. Gillespie, M. M. Gooey, W. Gove, J. Gray, A. H. Green, A. O. Green, K. J. Grice, W. H. Hailes, C. W. K. Hardy, L. A. Hardy, D. I. Hart, J. R. Hasker, J. G. E. Hayden, H. T. Hayes, P. G. Hayes, R. R. C. Hayes, J. I. Hayward, E. P. Hennessy, J. E. P. Hogg, J. Horan, J. A. Horan, B. L. Hellings, R. N. Howard, B. L. Hughes, J. F. Hughes, W. E. A. Hughes-Jones, V. Hurley, Mildred Hutchings, A. W. M. Hutson, A. V. Jackson, H. S. Jacobs, M. Jacobs, C. H. R. James, J. A. James, T. W. Jenkins, L. W. Johnston, W. W. S. Johnston, H. B. Kay, G. A. Kaye, E. V. Keogh,

B. T. Keon-Cohen, R. Kiel, E. S. J. King, W. E. King, V. E. Knight, N. Laidlaw, W. R. Lane, E. F. Langley, J. O. Lavarach, R. S. Lawson, C. J. N. Leleu, W. M. Lemmon, W. W. Lempriere, D. R. Leslie, I. A. M. Le Soeuf, A. E. Lincoln, E. F. Lind, C. W. B. Littlejohn, W. H. Long, D. O. Longmuir, G. C. Love, R. R. Macdonald, A. J. G. Mackay, Winifred Mackenzie, J. P. Major, C. Manson, A. D. Matheson, T. R. Matson, R. B. Maynard, A. C. Mendelsohn, H. D. B. Miller, J. Moriet, M. Morris, G. N. Morris, L. G. Morton, G. B. Murphy, I. S. M. Murphy, H. F. G. McDonald, A. H. McGregor, T. A. McLean, junior, H. McLorinan, S. J. Newing, F. K. Norris, C. W. Nye, E. D. O'Brien, P. N. O'Donnell, R. Officer, C. H. Osborn, R. G. Orr, G. M. Oxer, P. J. Parsons, T. B. C. Patrick, M. M. Perl, G. Pern, R. B. Perrins, H. A. Phillips, D. C. Pigdon, S. Plowman, W. Pook, M. L. Powell, D. A. Pritchard, D. Pryde, K. C. Purnell, C. F. H. Pyman, J. Ray, M. A. Rees, W. D. Refshauge, A. Richardson, S. F. Reid, C. A. M. Renou, K. E. Rex, A. H. Robertson, T. E. G. Robertson, W. A. E. Robertson, B. J. Robinson, G. S. Robinson, M. H. Robinson, W. J. McL. Robinson, R. McK. Rome, W. McI. Rose, K. C. Ross, C. W. Ross, L. E. Rothstadt, L. M. Routh, K. F. Russell, E. D. M. Ryan, M. H. M. Ryan, V. E. Sampson, C. E. Sawrey, J. J. Searby, B. A. Serjeant, D. N. L. Seward, J. E. Sewell, S. A. Sewell, H. Shannon, A. Sherwin, H. N. Silverman, A. J. M. Sinclair, R. H. Small, J. A. Smeal, J. Smibert, H. Smith, H. G. Smith, H. R. Smith, J. Smith, junior, L. Smith, P. G. Smith, J. C. Stewart, J. B. Somerset, N. L. Spiers, N. L. Spiers, junior, J. R. Stawell, T. H. Steel, F. D. Stephens, W. B. Stevens, H. C. Stone, R. F. A. Strang, C. Sullivan, H. F. Summons, W. Summons, C. E. Sutherland, T. G. Swinburne, D. J. Thomas, D. L. G. Thomas, G. C. V. Thompson, S. Thomson, M. C. J. Thornton, R. G. Tonkin, S. L. Townsend, L. G. Travers, H. F. Tucker, F. G. Tuddenham, E. M. Tymms, T. L. Tyrer, A. G. R. Uglow, T. W. Vorrath, R. Wall, W. H. Ward, R. Warden, H. A. W. Watson, J. Watson, R. W. Weaver, L. B. Webb, A. Weigall, G. R. Weigall, E. R. White, J. G. White, N. B. White, J. R. Williams, S. W. Williams, I. Wood, M. F. A. Woodruff, D. L. Yoffa.

Reports of Subcommittees.

Owing to the many demands on the time of members, meetings of subcommittees were reduced in number during the year.

Ethics Subcommittee.

The subcommittee met on five occasions and the following were the attendances:

Dr. Cahill	5	Dr. Smith	2
Dr. Davies	5	Dr. Major	2
Professor Allan	4	Dr. Ashton	1
Dr. Graham	4	Dr. Morris	1
Dr. Colville	3	Dr. Mollison	0

Members were reminded during the year that it is the duty of a practitioner to refuse to meet in consultation an unregistered person.

A member enquiring whether a general practitioner could collect and remit fees to a pathologist who was a legally qualified medical practitioner was advised that the *Medical Act* debarred the collection of such fees.

The alleged relationship of a member with an organization under lay control, which canvasses for patients, is under investigation.

Legislative Subcommittee.

The subcommitte met on two occasions and the following were the attendances:

Dr. Ashton	2	Dr. Green	1
Dr. Colville	2	Dr. Littlejohn	1
Dr. Davies	2	Dr. Dale	0
Professor Allan	1	Dr. Gowland	0

The meetings of the subcommittee were devoted to the consolidation of the Rules of the Branch, which are now being reprinted, and copies of which will be forwarded to members of the Branch before the end of the year.

Organization Subcommittee.

The subcommittee met on nine occasions and the following were the attendances:

Dr. Fitzgerald	9	Dr. McAree	4
Dr. Box	8	Dr. Gowland	3
Dr. Cahill	8	Dr. Hughes	3
Dr. Fethers	7	Dr. Dale	2
Dr. Neal	6	Dr. Ettelson	2
Dr. Lear	5	Dr. Littlejohn	2
Dr. Smith	5	Dr. Byrne	2
Dr. Weigall	5	Dr. Carter	1
Dr. Graham	4	Dr. Ashton	0
Dr. Green	4		

Negotiations with the Friendly Societies' Association for an increased capitation fee, commenced in 1940, were continued in the early months of this year, but reached an impasse on the refusal of the societies to agree to an increased rate. A special "Ways and Means" Subcommittee was then appointed to prepare plans to obtain an increase, but, in May, the Prices Commissioner intervened, requesting that no further steps be taken to alter the capitation rate without his consent. A memorandum supporting our claim was submitted to the Commissioner, to which the societies sent a rejoinder, and which was in turn answered by the Branch Council. The Commissioner's decision in the matter is still awaited.

There being reason to believe that an unregistered alien, practising in a country district, held appointments as medical officer to certain friendly societies, the matter was placed before the Registrar of Friendly Societies, who expressed the opinion that the appointment of an unregistered person to provide medical service to lodge members was a contravention of the *Friendly Societies Act*, and his opinion was transmitted to the grand lodges concerned.

A member was advised that, under his agreement with the friendly societies, he was obliged to attend a lodge member entering a private hospital.

The friendly societies were informed that an unfinancial lodge member may be replaced on a medical list either by payment of arrears or after reexamination and payment of a reexamination fee; that if an unfinancial lodge member obtained medical service during the period when he was not on a medical list, he incurred a responsibility for private fees for that service and that the reason for demanding payment of arrears was to preserve the member's right to future benefit by establishing continuity of membership.

A doctor enquiring as to his right to charge a fee to a lodge member operated on for a ruptured ectopic pregnancy in a "public" ward and later transferred to an "intermediate" ward was advised that under the Common Form of Agreement, the condition being "miscarriage", he was entitled to charge for services rendered to the patient while in the "intermediate" ward, and the fee was a matter for mutual arrangement.

The question of payment for provision of medical services in a national emergency in connexion with "A.R.P." work, care of evacuated children *et cetera*, was referred for the consideration of the Federal Council.

The Federal Council was informed that in the opinion of the Branch Council arrangements for medical service to widows and children under the care of the Repatriation Commission should be on a Commonwealth-wide basis at the rate of 26s. metropolitan and 32s. country; the terms of service should be those under the Model Common Form of Agreement, covering contract practice; and, further, that payments to doctors should be made direct by the Repatriation Commission or through the British Medical Association, so that the patients might have a wider choice of doctor. The matter is still under discussion between the Federal Council and the Repatriation Commission.

Members were requested to exhibit the following notice in their waiting rooms:

> Patients who normally would consult another doctor now absent on war service are asked to inform me of this fact. This information is desirable to conserve the interests of the absentee doctor.

The unsatisfactory position regarding the salaries of many medical officers of health, referred to in previous reports, continues, although the Public Health Commission has agreed to a scale of salaries acceptable to the Association.

Science Subcommittee.

The subcommittee met on three occasions and the following were the attendances:

Dr. Graham	3	Professor Allan	2
Dr. McAree	3	Dr. Searby	0
Professor MacCallum	3		

Representations by the Australian Chemical Institute that clinical laboratories should be controlled by properly qualified persons were supported and the matter referred to the Federal Council.

It was suggested to the Federal Council that a memorandum by Dr. F. L. Morgan, on protamine zinc insulin, be published in THE MEDICAL JOURNAL OF AUSTRALIA for the information of members.

The question of the use of Thomas splints in civil ambulances has been referred for the opinion of the Victorian Civil Ambulance Association.

The syllabus of scientific meetings for the year consisted of 13 monthly meetings and three clinical meetings. Owing

to restrictions on travel occasioned by petrol rationing, no country branch meetings were held.

The following were the lectures and the subjects dealt with:

Monthly Meetings:

February.—Dr. P. A. Maplestone: "Tropical Diseases".

March.—Dr. A. M. Hill: "Modern Aspects of Puerperal Sepsis".

April.—The Fifth Syme Triennial Memorial Lecture, by Sir Henry Newland: "War Surgery".

Branch Meeting:

May.—Emeritus Professor W. A. Osborne: "Cryptotrophic Factors in Nutrition"; special meeting—Major-General F. A. Maguire: "Coordination of the Medical Profession".

June.—Dr. John Dale and Dr. Ramsay Mailer: "The Social Aspects of Medicine".

July.—A symposium on "Common Affections of the Ear, Nose and Throat", at which papers were read by Dr. Eric Gutteridge, Dr. Raymond Hennessy, Dr. John Shaw and Dr. T. G. Wynne.

August.—A symposium on "Modern Methods in the Diagnosis of Tuberculosis", at which the speakers were Dr. K. Hallam, Dr. H. M. James, Dr. W. S. Newton and Dr. R. Webster.

September.—Dr. H. M. L. Murray: "Industrial Fatigue".

October.—Branch meeting—Professor R. D. Wright: "Recent Developments of Knowledge of Liver Functions and Behaviour"; special meeting—the eighth Sir Richard Stawell Oration: "The Principle of Health", by Dr. C. I. McLaren.

November.—Branch meeting—Dr. H. Mortensen: "The Problem of Bladder Neck Obstruction"; special meeting—Colonel H. C. Disher: "Some Experiences in the Middle East, including the Libyan Campaign".

Clinical Meetings:

June.—Saint Vincent's Hospital.

September.—Women's Hospital.

October.—Children's Hospital.

The Syme Triennial Memorial Lecture.—The fifth Syme Triennial Memorial Lecture was delivered on April 2, 1941, by Sir Henry Simpson Newland, the subject being "War Surgery".

The Sir Richard Stawell Oration.—The eighth Sir Richard Stawell Oration was delivered on October 29. Dr. A. S. Anderson read a paper by Dr. C. I. McLaren of the Paton Memorial Hospital, Chinju, entitled "The Principle of Health".

Hospital Subcommittee.

The subcommittee met on six occasions and the following were the attendances:

Dr. Graham	6	Dr. Ettelson	3
Dr. Smith	4	Dr. Weigall	3
Dr. Colville	3	Dr. Embelton	1

The necessity for the establishment of a Central Admission Bureau to facilitate arrangements for the admission of patients to hospitals has long been obvious and further unsuccessful attempts were made during the year to have such a bureau inaugurated.

A subcommittee to consider the question of obstetric bed accommodation in Melbourne was established early in the year and cooperated with the Charities Board in obtaining and disseminating information regarding the availability of obstetric beds.

The honorary staff of a public hospital, inquiring as to the duty of the hospital in treating emergency cases, was advised that, in the opinion of the Branch Council (*a*) an emergency is a condition which, in the opinion of the medical officer on duty, demands immediate attention, and (*b*) that the following classes of persons are entitled to treatment at a public hospital, (i) in an emergency, any member of the community, and (ii) not in an emergency or when the emergency has passed, the disposal of a patient must be determined in accordance with the provisions of the *Hospitals and Charities Acts*.

Representatives of the newly formed Hospital Residents' Group submitted proposals designed to overcome some of the present difficulties regarding appointment of resident medical officers, and the Branch Council has decided to request the clinical school hospitals to appoint their resident staffs as soon as possible after the graduation of applicants, and other hospitals employing resident medical officers are being asked if they would cooperate with a committee under the ægis of the Branch Council, established to assist in the appointment of resident medical officers.

The honorary medical staffs of metropolitan and base hospitals have been asked for their opinions on the question of payment for medical service to victims of street accidents coming under the provisions of the *Motor Car (Third Party) Insurance Act*, which makes no adequate provision to meet the costs of medical care in such cases.

Workers' Compensation Subcommittee.

The subcommittee met on seven occasions and the following were the attendances:

Dr. Smith	7	Dr. Byrne	4
Dr. Colville	6	Dr. Searby	3
Dr. Graham	6	Dr. Ashton	0

Negotiations with the Fire and Accident Underwriters' Association of Victoria for the establishment of a schedule of fees, applicable in cases where the attending doctor looks to the insurer for payment of his fees for services rendered to an injured "worker" were concluded during the year and an agreement embodying a schedule of fees was determined. That agreement and other relevant matters were set out in a brochure, "Workers' Compensation in Victoria", which was distributed to members.

The agreement with the Fire and Accident Underwriters' Association included provision for a joint adjudication committee to settle disputes, and the committee is now functioning.

Discussions regarding a schedule of fees for radiological examinations of injured "workers" are proceeding.

War Emergency Subcommittee.

The subcommittee met on five occasions and the following were the attendances:

Dr. Lear	5	Dr. Gowland	1
Dr. McAree	4	Dr. Littlejohn	1
Dr. Hughes	2		

The subcommittee considered several applications from members desiring to commence practice, and in each instance made a recommendation to the Council based on consideration of the effect such commencement of practice might have on the interests of members absent on service.

Finance, House and Library Subcommittee.

The subcommittee met on eleven occasions and the following were the attendances:

Dr. Mollison	11	Dr. Major	5
Dr. Fetherston	10	Dr. Smith	2

So that the relevant rule of the Branch would conform with the similar rule in the other States, the rule covering the payment of subscriptions was altered during the year to provide that members' subscriptions must be paid on or before December 31 in each year.

The offer of the Australasian Medical Publishing Company, Limited, to grant a rebate in respect of members on active service was accepted with appreciation.

The Honorary Treasurer's report and statement of receipts and expenditure of the Branch and the Medical Society of Victoria will be presented to the monthly Branch meeting in February.

Thanks are again due to the British Medical Insurance Company for the continued grant of moneys to the funds of the Medical Society of Victoria.

The following gifts are acknowledged, for which Council's thanks on behalf of members have already been made to the donors: Sir James Barrett, portraits and diplomas; Dr. Frank Kerr, medical dispensing box.

Honorary Librarian's Report.

The attendance of members has been good throughout the year, in spite of the absence of many now on active service.

Books and journals in the library have recently been sprayed and cleaned as a safeguard against silverfish and other insects.

A survey of journals shows that none has been lost—our sets are complete. Some sets date back for almost 120 years.

Duplicate books were presented to both the Fourth and Seventh Australian General Hospitals.

Two issues of *The British Medical Journal* were not delivered during the year, probably due to enemy action, but duplicates have been received. Two *Lancets* are missing, but it is hoped that duplicates may be obtained in England.

The members of the Library Advisory Subcommittee are thanked for their valuable assistance in the selection of new books for the library.

Presentations to the library during the year have been made by the following, to whom our thanks are tendered: Dr. A. S. Anderson, Sir James Barrett, Wing-Commander W. D. Counsell, Dr. J. Newman Morris, the Education Department, the Editor of THE MEDICAL JOURNAL OF AUSTRALIA, the Council for Scientific and Industrial Research.

R. H. FETHERSTON,
Honorary Librarian.

Congratulations.

During the year the Council had pleasure in conveying congratulations to: Surgeon-Captain W. J. Carr, C.B.E., R.A.N., and Group-Captain E. A. Daley, R.A.A.F., on being made Honorary Physicians to the King; Air-Commodore T. E. V. Hurley, C.M.G., V.D., R.A.A.F., on being made Honorary Surgeon to the King; Sir Trent Ch. de Crespigny and Dr. B. T. Zwar, C.M.G., on their inclusion in the New Year's Honours List; and Colonel H. C. Disher, C.B.E., and Colonel H. G. Furnell, D.S.O., on their inclusion in the King's Birthday Honours List.

Social.

Farewell to members of the Fourth Australian General Hospital. On December 6, 1940, a late afternoon party was held in the library, at which members of the above hospital were entertained.

Golf.

The annual golf tournament was not held this year, owing to the small number of entries due to the exigencies of camp duties, the absence of members on active service and to petrol rationing.

The Income Insurance Fund.

The Income Insurance Fund is fulfilling the purpose for which it was established—the assistance of contributors engaged in full-time service with the forces who have suffered a loss of income by relinquishment of practice—but the number of contributors is disappointingly low.

Petrol Rationing.

At the request of the Commonwealth Liquid Fuel Control Board the Branch Council appointed a subcommittee which receives representations from members claiming an increase in their petrol allowances and makes recommendations to the State Liquid Fuel Control Board.

The E. H. Embley Prize Medal.

The examination for the eighth award was held in December, 1940, and the gold medal was presented at the March Branch meeting to the winner, Mr. M. M. McKeown, a senior medical student who has since graduated.

Medical War Relief Fund.

Contributions from Victoria to the Medical War Relief Fund for the assistance of colleagues suffering loss by enemy action in Great Britain amounted to £1,862 9s. 6d.

Obligations of Medical Witnesses.

A brochure on the legal obligations of medical practitioners regarding the furnishing of evidence and medical witnesses' fees was compiled and distributed to members during the year.

Federal Council.

The Federal Council met in March and in September. Full reports of the proceedings appeared in THE MEDICAL JOURNAL OF AUSTRALIA of April 12, 1941 (page 458), and November 1, 1941 (page 512).

The Branch Council entertained members of the Federal Council at dinner during the March meeting.

The Victorian Medical Benevolent Association.

Since last report the work of the association has continued to expand. In addition to minor grants, regular allowances have been made to needy members of the profession or to their widows or children. Eight such cases at present entail an outlay of £591 *per annum*.

The audited balance sheet presented at the last annual meeting showed an income of £532, derived from subscriptions £188 and interest on investments of the Permanent Fund £344.

It appears, therefore, that demands on the Association at the moment exceed the income by £59 *per annum*. The deficiency has been met out of a small reserve created by credit balances of former years. It is likely that in the future demands on the funds of the association will be heavier. The committee has given much consideration to the pressing question of finance. It believes that the best way to ensure a stable and steadily growing income is to increase the Permanent Fund, which now amounts to £8,700. It has decided to invite donations and bequests to the fund, and also to commence a practice which has grown up in similar associations in South Africa and Great Britain and proved very fruitful in adding to their funds.

This provides that "recognition of services rendered to one another by members of the profession may take the form, by mutual agreement, of a gift to the Permanent Fund, in the name of the doctor rendering the service". It is believed that the adoption of this practice would meet what is often an embarrassing situation and would make a valuable contribution to the Permanent Fund.

The committee thanks the Council of the British Medical Association for publicity and the collection of an annual subscription of five shillings from a majority of its members.

EDWARD L. GAULT,
Honorary Secretary.

British Medical Insurance Company of Victoria Limited.

The profit of the British Medical Insurance Company of Victoria Limited for the year ended April 30, 1941, was £1,330. This figure is an improvement on last year's profit of £1,278.

Donations were made as follow:

To the Medical Society of Victoria—					
Library Books	£69	2	3		
Cash	480	0	0		
Car Attendant	20	12	6		
Gestetner Duplicator	98	0	0		
				£667	14 9
To the Victorian Medical Benevolent Association				5	5 0
To Military Hospitals abroad				52	6 1
To Medical Relief Fund, London				26	17 1
To Geelong Subdivision, British Medical Association Library				25	0 0
				£777	2 11

The company now holds £2,325 of debentures in the Medical Society of Victoria, on which it is accepting interest at the rate of only 1%, which, of course, is another financial benefit to the Medical Society. Nine thousand and thirty-four pounds is invested in Commonwealth loans and £400 on deposit.

The directors appreciate the members' continued support of the company.

C. H. MOLLISON,
Chairman of Directors.

British Medical Agency Proprietary Limited.

With the absence of so many members of the profession on service, very few practices are being transferred, but the agency has received a fair share of the business offering.

C. H. MOLLISON,
Chairman of Directors.

Reports of Subdivisions.

Metropolitan.

South Central.—Meetings of the South Central Subdivision were held in November, 1940, and September, 1941. At the latter meeting the following resolutions were passed for submission to the Council: (*a*) that the financial status of patients applying for treatment at public hospitals be carefully investigated and that workers' compensation cases be referred after the first treatment to their own medical attendant; and (*b*) that interviewing officers at metropolitan public hospitals be made justices of the peace for the purpose of obtaining sworn declarations by patients to obviate fraud.

F. E. MCAREE,
Honorary Secretary.

Eastern.—One meeting was held, at which national insurance and other possible changes in medical practice were discussed.

KEITH H. HALLAM,
Honorary Secretary.

South-Eastern.—Office Bearers: President, Dr. R. M. Shaw; Vice-Presidents, Dr. John Adamson and Dr. G. Foreman; Honorary Secretary, Dr. B. D. Fethers. The annual meeting of the subdivision was held at the home of Dr. Nicholson on September 30. Eight members were present. The following resolutions were carried: (1) that no golf tournament be held this year; (2) that this meeting recommends that the members of the subdivision be informed by circular that the meeting reaffirms the desirability of reserving week-ends and one night a week free from consulting hours; and (3) that this meeting believes that the terms of the Wasley Award relating to income limit are not being observed, and urges the Council

to do all in its power to enforce compliance with this clause. Dr. Davies informed members of the position regarding insurance cases, treatment of widows of deceased members of the Australian Imperial Force, and the policy of the Federal Council regarding a general medical service.

B. D. FETHERS,
Honorary Secretary.

North-Eastern.—Two meetings were held during the year, at which discussions took place concerning the friendly society agreement, a national medical service and other matters. Dr. J. Cahill was reelected as Chairman of the subdivision, and Dr. Roseby was reelected as Honorary Secretary.

D. ROSEBY,
Honorary Secretary.

Country.

Geelong.—Office Bearers: President, Dr. C. W. Gale; Vice-President, Dr. D. A. Carter; Secretary and Treasurer, Dr. C. E. Backwell; Committee, Dr. Good, Dr. Roland, Dr. Hyett, Dr. McPhee; Council Representative, Dr. D. A. Carter; Convocation, Dr. R. G. McPhee. During the year eight meetings of the subdivision were held, the business being mainly centred about "A.R.P." work and the organization of civil and "A.R.P." medical services. In this connexion a committee has been appointed, consisting of Dr. McPhee, Dr. Cole and Dr. Piper.

C. E. BACKWELL,
Honorary Secretary.

Bendigo.—Office Bearers: President, Dr. E. Biggs; Vice-President, Dr. P. Goodman; Secretary and Treasurer, Dr. E. Sandner; Executive Committee, Dr. J. Long, Dr. J. Sharland, Dr. H. Catford and Dr. W. Turner; Library and Clinical Subcommittee, Dr. E. Sandner, Dr. W. Harrison, Dr. J. Sharland and Dr. C. Stanley; Council Representative, Dr. P. Goodman; Substitute Council Representatives, Dr. O. Donald and Dr. P. Slater; Convocation Representatives, Dr. O. Donald and Dr. E. Biggs. During the year two meetings of the subdivision and three meetings of the executive were held. Owing to war conditions it has been impossible to maintain a full programme of clinical meetings, but three were held in Bendigo, and the Northern Section held two.

The question of national health insurance has frequently come up for discussion and questions asked as to the activity of the Council.

A deputation of local practitioners waited on Mr. A. E. Cook, M.L.A., in order to attempt to obtain an amendment of the *Motor Car (Third Party) Insurance Act*. Mr. Cook was favourably impressed, and promised to place the matter before the Premier.

During the year the deaths of Dr. F. Burke Gaffney and Dr. A. Nankervis marked the passing of two staunch supporters of the Bendigo Subdivision.

E. SANDNER,
Honorary Secretary.

North-Eastern.—One meeting was held, at which the following Office Bearers were elected: President, Dr. G. V. Davies; Secretary, Dr. N. N. Harrington; Treasurer, Dr. E. W. Hands.

N. N. HARRINGTON,
Honorary Secretary.

North-Western.—Office Bearers: President, Dr. G. R. Felstead; Honorary Secretary, Dr. G. Forsyth; Representative on Council, Dr. F. Bonnin. One meeting only was held during the year, on October 26, 1940, which took the form of a lecture by Dr. Ivan Maxwell on chemical warfare. Petrol rationing severely affected any chance of holding any additional meetings, as many of the members would have to travel over 200 miles, and most would have to travel forty to sixty miles to attend a meeting.

G. FORSYTH,
Honorary Secretary.

South-Western.—The subdivision records with great regret the death on active service of Dr. S. I. Weir, of Terang. Dr. C. B. Berryman, Dr. J. Morlet and Dr. R. G. Tonkin are on active service with the forces. Dr. E. C. Varley was elected to the office of Vice-President of the subdivision in lieu of Dr. Morlet, who was granted leave of absence. The decision to hold meetings throughout the year has proved a wise one. The attendance at meetings has been about normal and, by holding them at central points, economy of travel has resulted. The first meeting for the year was at Hamilton, when Dr. Colin Macdonald spoke on "Radiological Difficulties". The meeting at Warrnambool was addressed by Dr. A. S. Anderson, who spoke on "Eye Conditions in General Practice", and the final meeting was at Mortlake, when Dr. John Turner spoke on "Rectal Diseases". The subdivision expresses its thanks to these speakers.

K. F. O'DONNELL,
Honorary Secretary.

Reports of Sections.

Ear, Nose and Throat.—Office Bearers: President, Dr. T. G. Millar; Honorary Treasurer, Dr. Cecil Cantor; Honorary Secretary, Dr. Eric Gutteridge; Committee, Dr. H. Watson, Dr. Walter Williams, Dr. George Swinburne and Dr. Leonard Johnston. This section has a membership list of 43 members. One meeting was held during the year.

ERIC GUTTERIDGE,
Honorary Secretary.

Obstetrics and Gynæcology.—Office Bearers: President, Dr. Arthur Wilson; Honorary Secretary and Treasurer, Dr. G. B. Bearham; Committee, Dr. E. R. White, Dr. R. W. Chambers, Dr. R. O'Sullivan, Dr. R. Fowler, Dr. Roberta Donaldson, Dr. L. S. Kidd, Dr. B. M. Sutherland and Professor R. Marshall Allan. During the year Professor English, Professor of Obstetrics in Singapore, lectured to the section, his subject being "Midwifery in Singapore".

GEORGE B. BEARHAM,
Honorary Secretary.

Anæsthesia.—Office Bearers: President, Dr. T. Whittam; Honorary Secretary and Treasurer, Dr. I. C. James. During the year two meetings have been held, one in February and the other in June. At the latter Dr. Kaye Scott spoke on "Evipan as an Intravenous Anæsthetic, with Special Reference to Radium Therapy". As so many members are on active service, both meetings were poorly attended.

I. C. JAMES,
Honorary Secretary.

Neurology and Psychiatry.—Only one meeting of this section has been held during the current year. This was on July 3, in the Medical Society Hall, and Major-General Maguire opened a discussion on the psychiatric organization for war. He referred to the problems which arise in the recruiting, training and embarkation of men of all classes, and appealed to members for their candid criticisms. The meeting was well attended, both by members of the section and other interested practitioners. Some spoke of their experiences in dealing with psychiatric cases in the last war, and others referred to newer forms of treatment applicable to cases of nervous disorder in the present conflict. Dr. H. F. Maudsley, the President of the section, occupied the chair.

REG. S. ELLERY,
Honorary Secretary.

Radiology.—No regular meetings were held this year, but one special meeting was held to discuss fees of radiologists in regard to workers' compensation cases.

KEITH HALLAM,
Honorary Secretary.

Hospital Residents' Group.—Office Bearers: Chairman, Dr. W. M. Ket; Secretary, Dr. B. Widmer; Treasurer, Dr. J. C. G. Hadley; Committee, Dr. D. R. McFarlane, Dr. I. A. N. McCallum, Dr. R. Phillips, Dr. H. E. Williams.

The initial meeting of the section took place on June 14, 1941. The membership is limited to junior members of the British Medical Association and to members of the Association who have been hospital resident medical officers in the preceding two years.

The following are the object, scope and purposes of the section:

1. To form a section within the scope of the British Medical Association which will bring to the notice of the younger members of the medical profession the medical problems of the future.
2. To form a liaison between the resident medical officers and the rest of the medical profession and to link up medical student bodies with the British Medical Association.
3. To discuss clinical material between the different metropolitan hospitals.
4. To promote the welfare of the hospital resident medical officers and junior members of the profession.
5. In conjunction with other bodies, to work in an effort to help in the assessment of public hospital requirements and in relation to any national activity, for example, war effort.

A clinical meeting on blood transfusion technique, demonstrated by representatives from five metropolitan hospitals, and a picture night, with films by courtesy of Dr. F. Tate and Dr. R. O'Sullivan, have been held.

B. WIDMER,
Honorary Secretary.

Ophthalmological Society.

The following is the report of the Victorian Branch of the Ophthalmological Society of Australia. The usual meetings have been held during the year. The formation of a school for partially sighted children has been inaugurated by the Education Department, and Dr. Eileen FitzGerald addressed members at a meeting on this subject. The third annual meeting of the society, lasting three days, was held in Melbourne this year and took the form of a series of lectures and demonstrations. Dr. Kevin O'Day is the President of the Victorian Branch for 1941.

T. a'B. TRAVERS,
Honorary Secretary.

Melbourne Permanent Post-Graduate Committee.

The following report is published on behalf of the Melbourne Permanent Post-Graduate Committee.

During the present year little post-graduate teaching has been arranged. In the previous year a number of courses was arranged for medical officers in the three fighting services, but apparently owing to difficulties in arranging attendances, no further requests for such courses have been made. The attendance at other courses arranged was very poor, as under present conditions medical practitioners have little spare time and there is a very limited supply of *locum tenentes*. The number able to give instruction during such courses has been greatly depleted by enlistments from the staffs of the teaching hospitals. The committee therefore decided that no set courses would be arranged during this year, but already attention is being directed to post-war instruction. Individual instruction is arranged for those who desire it, and lecturers are provided for meetings of country subdivisions of the British Medical Association.

E. GRAEME ROBERTSON,
Honorary Secretary.

On behalf of the Council,

H. BOYD GRAHAM, Acting-President.
G. WINTER ASHTON, Honorary Secretary.
C. H. DICKSON, Medical Secretary.

Owing to the loss of Mr. Ward's services as Financial Secretary on account of his appointment as Secretary of the Central Medical Coordination Committee, Dr. Dickson has been called upon to do a great deal of extra office work. In addition he has acted in a voluntary capacity as Secretary of the State Medical Coordination Committee, and many other duties have devolved upon him. He has been ably supported by the other members of the office staff, and we were fortunate to obtain the services of Mr. Tregoning as accountant.

On behalf of the Executive,

H. BOYD GRAHAM,
Acting-President.

INSTALLATION OF THE PRESIDENT FOR 1942.

Dr. H. C. Colville said that it gave him great pleasure to install his friend Dr. H. Boyd Graham as President. The position was somewhat unusual for Dr. Graham had been carrying out the duties of Acting-President for the past year. The arrangement was one on which members of the Branch might congratulate themselves as the form of the nominee was already known. Dr. Graham had carried out the duties of Acting-President in a way which made Dr. Colville feel that the Branch was more than fortunate to have him to fill the office for two consecutive years. Dr. Graham had at all times displayed the keenest interest and had never spared himself; he had not studied his own convenience and had given up much of his leisure time. Dr. Colville thought that the Branch was fortunate in having Dr. Graham as its President in what might be a very difficult year.

Dr. Graham said that he took the chair with some diffidence, as his form was already known. He would try to improve on the past year. He had great pleasure in testifying to the activity and zeal of the Council and Executive. The Branch could not be other than proud to have its President on active service. It was the duty of those who stayed at home to do their best to make things right for those unsettled in their practices. It would be his policy as President to do all in his power to support the interests of those serving their country. He thanked the Branch for the honour it had done him.

PRESIDENT'S ADDRESS.

Dr. Graham then asked Dr. Colville to read the address of the retiring President, Lieutenant-Colonel A. E. Coates.

Dr. Colville read the address and Dr. Graham said that when it was published study would reveal in it many points of value to those at home and those abroad.

Dr. J. A. Cahill moved a vote of thanks to Dr. Colville for reading the address; the vote was carried by acclamation.

VOTES OF THANKS.

Sir James Barrett moved a vote of thanks to the retiring members of Council. The Council did a great deal of necessary and useful work, and if he was any judge of the future it would have its hands full for the next year, when it would need all its knowledge and restraint to handle difficulties. The motion was carried by acclamation.

On the motion of Dr. F. L. Davies, seconded by Dr. J. O'Sullivan, it was resolved that Lieutenant-Colonel Coates should be thanked for his paper and for his services and that the message should be sent to him by cable.

Public Health.

THE PUBLIC HEALTH IN SOUTH AUSTRALIA.

THE annual report of the Central Board of Health of South Australia for the year ended December 31, 1940, has been issued. The report is a record of achievement and of vigilance on the part of the board in many aspects of public health. It is early pointed out that there must be no slackening of public health effort by health authorities on account of the war. "The policy of the Central Board is that there must be continued and vigorous attempts to maintain and to increase the intensity and range of health work in the community. Local Boards are being urged to follow that course and to permit no abatement of enthusiasm and action. Health risks are increased by war—all health authorities must remember that fact." The population of South Australia at December 31, 1940, was 598,091—a decrease of 372 since December 31, 1939. During the year under review there were 10,017 births and 5,708 deaths. Of infants aged under one year, 356 died—a rate of 35·83 per 1,000 births. The chief causes of infantile deaths were: prematurity, 104; congenital malformations, 45; birth injuries, 32; congenital debility, 8; other diseases of infancy, 40; enteritis and diarrhœa, 18; pneumonia, 50; whooping cough, 6; excessive heat, 2. Stillbirths numbered 268. The principal causes of death among the general population were: cardiac lesions, 1,345; cancer and other malignant tumours, 746; tuberculosis, 220; cerebral hæmorrhage, softening *et cetera*, 587; pneumonia, 319; bronchitis 77; nephritis (acute and chronic), 234; *diabetes mellitus*, 130; puerperal causes, 33; congenital debility, malformations *et cetera*, 240; suicide, 61; violence (except suicide), 326; diarrhœa and enteritis, 36; whooping cough, 17; diphtheria and croup, 23. The relative incidence of causes of death is comparable with the figures for recent years. Of the violent deaths, five were due to excessive heat, 82 to falls, 109 to motor car accidents, 9 to burns, 31 to drowning, 25 to railway and tramway accidents, 15 to accidents involving other means of transport, and 9 to firearms. A diphtheria immunization campaign was carried out during 1940, and approximately 6,550 children were treated. Anatoxin is provided free of cost by the Central Board of Health. Three sporadic cases of cerebro-spinal meningitis were reported. Psittacosis has been proclaimed an infectious disease, and human cases must be reported. In two instances carriers of typhoid fever infection have been discovered long after their original illness; in each case the discovery followed a routine investigation of a fresh case of typhoid fever. The inquiries made by the officer of health pointed to the possibility that the infection might have come from the earlier patient, and material was obtained for laboratory investigation. In one case the carrier had been in reasonably good health since the occurrence of the illness twenty-eight years previously; in the other the carrier was a woman, aged seventy-seven years, who was said to have had the infection when she was seventeen years old. "The promptness of the local boards' officers in detecting these sources of infection is highly commendable." The position with regard to the prevention and control of tuberculosis in South Australia is heartening. During 1940, 276 cases of pulmonary tuberculosis were reported and 183 deaths occurred; 1,323 patients suffering from pulmonary tuberculosis are under observation by local boards.

Taking the changes in population into account—360 thousand in 1900, and nearly 600 thousand in 1940—the declines in the case-rate and death-rate are dramatic. The number of cases reported is now only 46 per cent. of that at the opening of the century, and the deaths have dropped to 37 per cent. The falls have been fairly steady, year by year, throughout the period. The

halving of the case-rate and the drop of the death-rate to one-third the figure—in the relatively short space of 40 years—are astonishing facts.

The report goes on to state that, although the health status of South Australia is satisfactory, a warning must be given against "smug complacency"; only through the continued efforts of local boards will further victories be won in the fight for community health. It is also pointed out that, as in most countries where the social services are widening their scope, health departments are constantly limited in their activities by the inadequate amounts of money available to them. "The lesson that health work costs money has to be learnt and practised."

Correspondence.

A GENERAL MEDICAL SERVICE FOR AUSTRALIA.

SIR: Dr. H. R. R. Grieve, in his letter to THE MEDICAL JOURNAL OF AUSTRALIA of November 15, has put forward the proposition that the present form of medical practice in Australia is efficient, and that there is no need to consider replacing it with another, or to let anyone else do so. He shows, with some skill, the fine work that the profession has done in Australia in many different directions, and all that he says is true and the record is indeed a fine one.

It is also obvious from the letters that appear in your journal from time to time that he is not alone in these opinions. Therefore I feel it is worth while to answer these objections to an organized system, once and for all. This is meant in no sense as a criticism of our efforts in the past, but rather an indication of what remains to be achieved, and constitutes a sound reason why we should not rest on our laurels and be satisfied with what we have already achieved.

I am now about to commit a grave scientific fault and quote very approximate figures and estimates from memory; they may be 50% out, but that will not alter the conclusions to be drawn from them.

Every year in Australia about 3,000 people die from tuberculosis and about 30,000 are always suffering from it. We know that we have it in our power, given the necessary legislation, to discover any and every case of tuberculosis at an early stage, to cure the greater number of them and to prevent completely the spread of the disease. We are not doing it.

A somewhat similar number of persons dies each year from cancer of one form or another; some forms are more amenable to early diagnosis and treatment than others, but in types that are amenable, certain facts have been elicited. Take, for example, carcinoma of the rectum. It has been claimed by authorities who should know, and it is obvious to anyone who is familiar with the condition, that it is possible to diagnose the condition at a stage early enough to permit of cure in 80% or more of cases. What is actually occurring is that more than 80% of cases are already beyond hope of cure when they are first seen. Can we sit back and consider this a satisfactory state of affairs?

It is reasonable to assume that neither of these grave losses of life and health can be prevented under our present "system". If they could be and we are refraining from doing it we are committing a grave crime. Actually the patient does not come to us in time, and the only way we could induce him to do this is by education in the earlier signs and symptoms of the diseases that need a consultation, and we are not doing this to any significant extent.

I could continue to take each major cause of death and sickness in turn, and show how unnecessary it all is, and that we could largely prevent the suffering but are failing to do so. Since, in the back blocks of the Never Never, access to vital statistics at short notice is, to say the least of it, difficult, I will leave the analogy to complete itself.

Passing from the field of more strictly curative medicine, one further tilt may be permitted. We talk about preventive medicine, and unquestionably, as Dr. Grieve so ably points out, we are carrying out preventive medicine by preventing the onset and spread of infection in wounds, operations and childbirth by asepsis and antisepsis, by carrying out immunization of a proportion of our children, and so on, but it is obvious that real preventive medicine on the widest scale cannot be applied to every individual unless and until we see that individual before he ever becomes sick. It is so obvious as almost to be axiomatic, and yet, under our present system, we simply do not see the vast majority of patients until they are sick, indeed until they are ill enough to consider it worth while paying half a guinea to see a doctor.

Furthermore, our training is so overwhelmingly devoted to curative medicine that most of us would be rather at a loss to know what to do with people who came to us while still fit and asked us to keep them healthy.

Two things are perfectly obvious conclusions if we are to achieve the highest aims of medicine: (i) That we must train doctors to undertake the work of keeping the people healthy. This we are not doing now. (ii) That they must be given the opportunity to apply this training by seeing the people in their care regularly while they are still well. This also we are not doing now. These two reasons alone make it imperative that we adopt a more efficient mode of practice. They are not alone. Until we do these things we must realize that we are just touching on the veriest fringe of the best practice of medicine.

With the rest of Dr. Grieve's letter I am in complete agreement, especially his conclusions as to necessary Government action in respect of good food, good housing, and good medical attention supplied complete with all the aids to diagnosis.

Let us hope that we can do our duty and carry out the highest callings of our profession in keeping each individual in perfect health and efficiency of mind and body without substituting for our art "the cold power of the machine". I am certain we can. The question is: "Will we?"

Yours, etc.,

ALEXANDER MCQUEEN THOMSON,

Barrow Creek,
Northern Territory,
December 13, 1941.

MANPOWER.

SIR: The various reports on the examination of recruits and the cause of rejection are full of interest to anyone like myself who was concerned during the last war with the manpower problem from the medical point of view.

Britain conscripted 27% of her male population and bled herself white. She used all these conscripts in some fashion depending on their capacity medical and otherwise.

Australia did not act in this thorough-going fashion. The manpower problem in Australia has now become acute and urgent.

During the last war, whilst as president of a board I was doing my best to provide Field Marshal Allenby with men there was some criticism. The Medical General under whom I served received some complaints and someone asked him whether if he knew a soldier must die from some disease in six months would he send him to work? He replied, if I thought him fit to kill, or help to kill, some Germans before he died my answer is certainly—Yes. That reply expressed the commonsense view of a difficult problem.

Perhaps two instances will illustrate. Toward the end of the Great War men with vision in one eye and nothing in the other were admitted and used as batmen, cleaners and the like.

I was requested with my Board to investigate the case of a German officer who applied for release. He had a stiff knee, due to osteomyelitis and ankylosis in 1913. He enlisted and was employed at first in clerical work and then in army medical administration. He was a gentlemanly capable man, and the German authorities evidently wanted his brains for their work.

Yours, etc.,

JAMES W. BARRETT.

102-105, Collins Street,
Melbourne, C.1,
December 23, 1941.

EXAMINATION OF RECRUITS FOR THE ARMY.

SIR: I have read with interest many papers on examination of recruits for the services. Why, however, should young men with elevated blood pressure quite empirically be rejected? I know dozens of them who are in perfect health and excellent athletes who would make first-rate soldiers, but have been rejected.

Why also should men with perfect vision but defective hearing be rejected, whereas men with defective vision are accepted? Surely vision is the more important sense.

The number of rejects I have met because of flat feet and bunions is also large. Many of these are excellent athletes.

When a nation is fighting for its very existence surely a little more common sense is needed in medical examiners.

The question of future payment of pensions should never even be considered.

Yours, etc.,

F. W. SIMPSON.

179, St. George's Terrace,
Perth,
December 30, 1941.

SIR: In the medical examination of military recruits the subject of asthma has been cropping up. I have seen medical officers look worried when the recruit's statement includes asthma. I suggest a simple formula. (i) Ask the man to describe his "asthmatic" attack without leading questions. (ii) If he succeeds in describing what may be asthma, ask him did he seek and obtain medical treatment. If this plan does not eliminate asthma as a cause for exemption, defer him to obtain a medical certificate from the doctor who treated him in his attack, before deciding if he is fit or unfit.

From my experience in the last war, asthma was a rare disease among soldiers, and a still rarer cause for sending a man back from front-area service. I think it is also very rare amongst young men in civil life. Any mention of asthma should be carefully probed, as it may develop into a weapon for slackers. As a final word, I think an occasional asthmatic attack once in six months or so, which is immediately cured by adrenaline injection, should not be too seriously regarded by military authorities.

Yours, etc.,

S. M. O'RIORDAN.

"Killarney",
172 Avoca Street,
Randwick, New South Wales.
January 2, 1942.

A NATIONAL MEDICAL SERVICE.

SIR: I have followed with much interest the correspondence upon national medical service and the reports of the National Health and Medical Research Council and Federal Council of the British Medical Association upon same.

It is quite evident that a subtle attempt by a few idealists and officials is being made to destroy the ancient liberties of the medical profession and to introduce the thin edge of the wedge that may open the way towards a complete totalitarian scheme of economic and social control so beloved by the child-like exponents of Marxian socialism.

Before the medical profession accepts any such scheme the views of all its members should be ascertained after the evidence for and against such scheme has been placed fully before them.

The only democratic method of obtaining the views of all members is by means of a referendum and postal voting.

Each branch should therefore prepare by passing regulations providing for such referendum and giving the result of such referendum executive power.

As we are at present it is possible for a small meeting in one of the capital cities to pass a motion pledging the Branch to a course of action that may be quite out of harmony with the desires of the majority of members.

It is manifestly impossible for all or even a large majority of members to attend any branch meeting and non-attendance means disenfranchisements.

I cannot hope to deal with many aspects mentioned in your columns, but I would urge members who write to the journal to be careful of their statements, be sure of their facts, and construct their sentences so that the meaning may be clear.

I would like to cite two notable examples of error that have recently appeared in your columns.

Dr. Brown endeavours to draw "parallel" between the supply of railway transport and medical and health services. But such a parallel will not bear examination; it is utterly erroneous.

A railway supply service is a matter which can be regarded as static; that is, it can conform to a regular table of times and places—the demand for service can be fairly accurately gauged and accommodation forthwith provided *et cetera*; even with this comparatively easy administrative problem all know the many errors and imperfections in the best railway system, it by no means works perfectly, especially when controlled by Government, and the economic loss is often enormous.

But medical and health services can be regarded as dynamic, fluid, ever changing—no man can foresee the future of the demands *et cetera* upon his services, no man can regulate the times and places *et cetera* of his calls. We may liken railway administration to the control of a small creek, whereas medical practice could be in contrast likened unto the ocean where man's control stops by the shore; one cannot be likened to the other.

Dr. H. G. Wallace writes: "the overflowing hospitals and the tremendous invalid pension lists indicate how far from adequate that organization has been".

Now, sir, I submit the growing pensions list has nothing to do with medical practice. The invalid pension list is due to economic and social problems—the demand for pension rises and falls with the economic condition of the people—at present the demand is falling owing to the large employment in factories.

These criticisms are made solely to point out a serious fault in many correspondents—that of loose thinking. Loose thought and loose expression will be followed by faulty actions—correct thought is necessary for correct action.

The whole question of the medical services is based upon the economic position of the people—the National Health and Medical Research Council itself acknowledges this.

Therefore the primary thing to do is to raise the economic condition of the people which in Australia as elsewhere is unjust and absurdly low.

To attempt any other step first will merely be a palliative and will result ultimately in a further lowering of the economic condition of the masses by the increased taxation burden necessary to finance any of these dream-like schemes.

Dr. Maude is the bravest of the advocates of socialization of medicine, for he really tells the truth about the whole Marxian Utopia when he declares: "If health cannot be sold to the community it must be forced on it."

It deeply grieves me to see a member of our profession writing in this manner.

I thought that for hundreds of years we have been struggling to evolve from force and that today thousands are dying to protest against the application of force in their lives.

We cannot force men to be good or bad, neither can we force them to be healthy. We may delude ourselves that such could happen, but sometime and somewhere the dam will eventually break and civilization again be in jeopardy. It is only through education, a slow and painful discipline, that men can rise to higher things—even good health.

However, I cannot trespass any further on your space, but I intend to deal with the whole question of the socialization of medicine in a debate that will be broadcast from station 3DB-3LK on Saturday, the seventh of February, at 8 p.m. (Heckle Hour).

I trust that some of my colleagues may do me the honour of listening in on that evening—they may be amused if not instructed.

Yours, etc.,

PAUL G. DANE.

111, Collins Street,
Melbourne,
January 7, 1942.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 279, of December 31, 1941.

NAVAL FORCES OF THE COMMONWEALTH.

Permanent Naval Forces of the Commonwealth (Sea-Going Forces).

Emergency List.

Promotion.—Surgeon Lieutenant Kingsley Edric Fenton Dixon Hudson is promoted to the rank of Surgeon Lieutenant-Commander, dated 20th November, 1941.

Citizen Naval Forces of the Commonwealth.

Royal Australian Naval Volunteer Reserve.

Confirmation in Rank.—Surgeon Lieutenants (on probation) Robert Samuel Irwin and Paul Laurence Dorney are confirmed in the rank of Surgeon Lieutenant, with seniority in rank of 1st September, 1940, and 9th September, 1940, respectively.

AUSTRALIAN IMPERIAL FORCE.

Australian Army Medical Corps.

Major M. A. Rees is appointed to command an Australian Army Medical Corps Training Wing, *vice* Major (Temporary Lieutenant-Colonel) W. P. MacCallum, D.S.O., M.C., 17th October, 1941.

Permanent Supernumerary List.

Major W. E. A. Hughes-Jones is transferred from Australian Army Medical Corps, 14th October, 1941.

AUSTRALIAN MILITARY FORCES.

AUSTRALIAN ARMY MEDICAL CORPS.

Seventh Military District.

Captain (provisionally) F. K. S. Hirschfeld is transferred from Australian Army Medical Corps, 1st Military District, and to be Major (temporarily), 9th December, 1941.

Eighth Military District.

Captain (provisionally) B. M. J. Conlon is transferred from 1st Military District, 21st November, 1941.

Northern Command.

First Military District.

Honorary Captain H. Green is appointed from the Reserve of Officers (A.A.M.C.), and to be Captain (provisionally), 17th November, 1941.

To be Captain (provisionally).—Alexander Roy McGregor, 17th November, 1941.

The resignation of Captain E. Mansfield of his commission is accepted, 18th November, 1941.

To be Honorary Captains.—Harold William Arthur Forbes, John Beaumaris Dick Smith and Patrick Redmond Walsh, 21st November, 1941; Brucklay Robertson Vincent Forbes, Charles Arthur Holmes, Robert Archibald McCullagh and Eric Francis Alixis Shaw, 24th November, 1941.

Honorary Captain F. K. S. Hirschfeld is appointed from the Reserve of Officers (A.A.M.C.), and to be Captain (provisionally), 8th November, 1941.

Eastern Command.

Second Military District.

Lieutenant-Colonel A. C. Thomas is appointed from the Reserve of Officers (A.A.M.C.), 1st October, 1941.

Honorary Major W. I. T. Hotten is appointed from the Reserve of Officers (A.A.M.C.), and to be Major (provisionally), 25th November, 1941.

Honorary Major A. H. Baldwin is appointed from the Reserve of Officers (A.A.M.C.), and to be Major (provisionally), 18th November, 1941.

Honorary Captain L. E. Jabour is appointed from the Reserve of Officers (A.A.M.C.), and to be Captain (provisionally), 24th November, 1941.

Lieutenant C. M. Swirles is appointed from the Reserve of Officers (Inf.) and to be Captain (provisionally), 17th November, 1941.

Lieutenant-Colonel A. E. M. Moir relinquishes the command of a General Hospital and is transferred from 7th Military District, 28th September, 1941, and is appointed to command a Convalescent Depot, 29th September, 1941.

The resignation of Honorary Captain O. H. Schneider of his commission is accepted, 1st February, 1942.

To be Honorary Captains.—John Campbell Church, 18th November, 1941; Robert Eddington Rome Gillespie, 19th November, 1941; and John Henry Priestley, 24th November, 1941.

Lieutenant-Colonel A. J. Mackenzie, V.D., is appointed from the Reserve of Officers (A.A.M.C.) to command a General Hospital, 22nd September, 1941.

Captain (provisionally) C. W. England is transferred to the Reserve of Officers (A.A.M.C.), 4th December, 1941, with the honorary rank of Captain.

Honorary Captains H. R. Macourt and D. L. Graham are appointed from the Reserve of Officers (A.A.M.C.), and to be Captains (provisionally), 18th November, 1941, and 24th November, 1941, respectively.

To be Honorary Captains.—Neil Douglas Campbell, 25th November, 1941; Clifford Errol Brake and Vivian Roy Elphick, 1st December, 1941.

Southern Command.

Third Military District.

To be Major (temporarily).—Captain V61103 N. P. Long, 17th November, 1941.

To be Captains (provisionally).—Ian Oliver Stahle, 17th November, 1941, and Wilbur Darcy Curtis and Robert Henry Symington, 24th November, 1941.

Captain (Temporary Major) V61333 N. L. Dodd relinquishes the temporary rank of Major and is placed on the Retired List, 14th November, 1941.

To be Captain (provisionally).—Cyrus Arvon Jones, 24th November, 1941.

The notification respecting the appointment of Honorary Captain K. H. Tweeddale which appeared in Executive Minute No. 161/1940, promulgated in *Commonwealth Gazette* No. 181 of 1940, is withdrawn.

Fourth Military District.

Lieutenant J. Fairley is transferred from the Reserve of Officers (Inf.) and to be Honorary Captain, 24th November, 1941.

Captain (Honorary Major) P. S. Messent is appointed from the Reserve of Officers and to be Major (provisionally), 6th November, 1940.

Honorary Captain S20 J. S. Stewart is appointed from the Reserve of Officers and to be Captain (provisionally), 29th July, 1940, and is placed on the Retired List, 24th November, 1941.

To be Major (temporarily).—Captain (provisionally) J. R. Cornish, 16th October, 1941.

To be Honorary Captains.—Richard Edmund Britten Jones and Frederick John Laycock, 3rd December, 1941.

Sixth Military District.

To be Honorary Major.—William Keverall McIntyre, 25th November, 1941.

The provisional appointment of Captain (Temporary Major) L. N. Gollan is confirmed.

To be Honorary Captain.—Thomas Robert Gaha, 1st December, 1941.

Western Command.

Fifth Military District.

Honorary Captain W16650 T. L. Williams is appointed from the Reserve of Officers (A.A.M.C.), and to be Captain (provisionally), 24th October, 1941.

To be Honorary Captain.—Mary Clarenza Irvine, 24th November, 1941.

Captain J. B. Hogg is appointed from the Reserve of Officers, 29th July, 1940 (in lieu of the notifications respecting the appointment of Captain (provisionally) J. B. Hogg which appeared in Executive Minutes Nos. 49/1941 and 177/1941, promulgated in *Commonwealth Gazettes* Nos. 50 of 1941 and 197 of 1941, respectively).

Honorary Captain W16416 G. L. Myles is appointed from the Reserve of Officers (A.A.M.C.), and to be Captain (provisionally), 25th September, 1941.

DECORATIONS.

His Majesty the King has been pleased to confer the following decorations on medical practitioners serving with the Australian Army Medical Corps.

Commander of the Most Excellent Order of the British Empire (Military Division): Colonel William Wallace Stewart Johnston, D.S.O., M.C., Colonel Norman Lennox Speirs, V.D.

Officer of the Most Excellent Order of the British Empire (Military Division): Lieutenant-Colonel John Colquhoun Belisario, Lieutenant-Colonel Bertram Speakman Hanson, Lieutenant-Colonel Noel Hunter West Saxby, Major Bruce Maitland Carruthers.

Companion of the Distinguished Service Order: Colonel Frank Kingsley Norris, Lieutenant-Colonel George Brumfit Gibb Maitland, D.C.M., Lieutenant-Colonel Arthur William Morrow.

LECTURE IN ADELAIDE.

The Deputy Director of Medical Services of the Fourth Military District announces that a lecture will be delivered by Colonel H. C. Disher at the Institute of Medical and Veterinary Science, Adelaide, on Thursday, January 22, 1942, at 8.30 o'clock p.m. The subject of the lecture will be "Army Medical Work Abroad".

National Emergency Measures.

MEDICAL EQUIPMENT.

THE Medical Equipment Control Committee desires to direct the attention of all members of the medical profession to the following information.

Surgical Instruments.

The manufacture of surgical instruments in Australia has been developed and increased to a very large degree to meet service demands. These demands have been standardized insofar as types of instruments are concerned. The whole industry is fully occupied in this work. All medical practitioners are therefore requested to refrain from placing orders for special instruments, because firms are naturally reluctant to disappoint their customers and may be tempted to take workmen from essential defence work in order to fulfil these non-essential demands.

It is desired that all practitioners should cooperate, not only in the direction suggested above, but also by lending instruments to each other when necessary in order to make stocks at present in Australia sufficient to meet all reasonable demands.

Glycerine.

Glycerine is urgently required for munition purposes, and the greatest economy is necessary in its use. Its sale has been controlled by regulation, but some has been reserved for medical use. Do not abuse this privilege.

Liquid Paraffin and Soft Paraffin.

Liquid paraffin and soft paraffin are imported and great care must be taken to make stocks last as long as possible. It is desired that other laxatives than paraffin should be ordered when possible and that every effort should be made by adjusting diets to lessen the demand for liquid paraffin which at present is used in an indiscriminate and wasteful manner. Stocks of soft paraffin can be conserved by care in the quantities of ointments ordered for therapeutic reasons.

Waste of Antiseptics et cetera in Theatre Work.

It is a common practice to pour out antiseptics on theatre trays in larger quantities than are actually required. All surgeons are requested to see that waste of this kind is avoided.

Australian Medical Board Proceedings.

TASMANIA.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Act*, 1918, of Tasmania, as duly qualified medical practitioners:

Pulsford, Margaret Joan Bronte (formerly Todd), M.B., B.S., 1940 (Univ. Sydney), Hobart.
Courtney, Geoffrey Charles Palliser, M.B., B.S., 1925 (Univ. Melbourne), Oatlands.
Stegmann, Frank, M.B., B.S., 1940 (Univ. Melbourne), Launceston.

The *Tasmanian Government Gazette* of December 10, 1941, publishes a correction to the list of duly qualified medical practitioners from which was taken our announcement of November 29, 1941, under the caption of Australian Medical Board Proceedings. The correct name of the practitioner is:

Churton, David Philip, M.B., B.S., 1941 (Univ. Melbourne), Launceston Public Hospital.

Medical Appointments.

Dr. Basil Frederick Roberts Stafford has been appointed Director of Mental Hygiene, and also Medical Superintendent, Brisbane Mental Hospital, in pursuance of the provisions of *The Public Service Acts*, 1922 *to* 1924, and *The Mental Hygiene Act of* 1938, of Queensland.

Dr. Harold Picton Clark has been appointed a Medical Officer in the Department of Public Instruction, New South Wales.

Dr. Annie Winifred Wall has been appointed an Honorary Assistant Anæsthetist, Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Playford D'Arcy O'Connor has been appointed Government Medical Officer at Tullamore, New South Wales.

Books Received.

"Infant Feeding", by V. L. Collins, M.D., M.R.C.P., D.C.H.; Second Edition; 1941. Melbourne: W. Ramsay (Surgical) Proprietary Limited. Demy 8vo, pp. 76. Price: 4s. net.

"Ophthalmic Nursing", by M. H. Whiting, O.B.E., M.A., M.B., B.Ch., F.R.C.S., with an introduction by Sir John Parsons, C.B.E., D.Sc., F.R.C.S., F.R.S.; Third Edition; 1941. London: J. and A. Churchill Limited. Crown 8vo, pp. 171, with 54 illustrations. Price: 6s. net.

"The M.B., B.S. Finals: A Collection of the Papers Set at the London M.B., B.S. Examination for the Years 1925-1940, Classified and Arranged in Suitable Sub-Divisions", by F. Mitchell-Heggs, M.B., B.S., F.R.C.S.; Second Edition; 1941. London: J. and A. Churchill Limited. Demy 8vo, pp. 112. Price: 7s. 6d. net.

"Happy Marriage", by N. E. Himes; English edition revised by L. S. Florence; 1941. London: George Allen and Unwin Limited. Demy 8vo, pp. 368, with charts. Price: 12s. 6d. net.

"Fourth Addendum to the British Pharmacopœia, 1932", published under the direction of the General Council of Medical Education and Registration of the United Kingdom; 1941. London: Constable and Company Limited. Demy 8vo, pp. 67.

"Aids to Anæsthesia", by V. Goldman, L.R.C.P., M.R.C.S., D.A., R.A.M.C.; 1941. London: Baillière, Tindall and Cox. Foolscap 8vo, pp. 243, with 58 illustrations. Price: 5s. net.

"Massage and Remedial Exercises in Medical and Surgical Conditions", by N. M. Tidy; Fifth Edition; 1941. Bristol: John Wright and Sons Limited. Demy 8vo, pp. 475, with illustrations. Price: 17s. 6d. net.

"Statistical Methods for Research Workers", by R. A. Fisher, ScD., F.R.S., Eighth Edition, revised and enlarged; 1941. Edinburgh: Oliver and Boyd. Demy 8vo, pp. 359, with diagrams. Price: 16s. net.

"The Treatment of Infantile Paralysis in the Acute Stage", by E. Kenny; 1941. Minneapolis: Bruce Publishing Company. Medium 8vo, pp. 304, with illustrations. Price: $3.50 net.

Diary for the Month.

JAN. 30.—Tasmanian Branch, B.M.A.: Council.
JAN. 23.—Queensland Branch, B.M.A.: Council.
JAN. 28.—Victorian Branch, B.M.A.: Council.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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